211 CMR 52.00: MANAGED CARE CONSUMER PROTECTIONS AND ACCREDITATION OF CARRIERS

52.01: Authority

211 CMR 52.00 is promulgated in accordance with authority granted to the Commissioner of Insurance by M.G.L. c. 175, § 24B, and M.G.L. c. 176O, §§ 2 and 17.

52.02: Applicability

211 CMR 52.00 applies to any carrier that offers for sale, provides or arranges for the provision of a defined set of health care services to insureds through affiliated and contracting providers or employs utilization review in making decisions about whether services are covered benefits under a health benefit plan. A carrier that provides coverage for limited health services only, that provides specified services through a workers' compensation preferred provider arrangement, or that does not provide services through a network or through participating providers shall be subject to those requirements of 211 CMR 52.00 as deemed appropriate by the Commissioner in a manner consistent with a duly filed application for accreditation as outlined in 211 CMR 52.06(2).

52.03: Definitions

As used in 211 CMR 52.00, the following words mean:

Accreditation, a written determination by the Bureau of Managed Care of compliance with M.G.L. c. 176O, 211 CMR 52.00 and 105 CMR 128.000.

Administrative disenrollment, a change in the status of an insured whereby the insured remains with the same carrier but his or her membership may appear under a different identification number. Examples of an administrative disenrollment are a change in employers, a move from an individual plan to a spouse's plan, or any similar change that may be recorded by the carrier as both a disenrollment and an enrollment.

Adverse determination, a determination, based upon a review of information provided, by a carrier or its designated utilization review organization, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness.

Ambulatory review, utilization review of health care services performed or provided in an outpatient setting, including, but not limited to, outpatient or ambulatory surgical, diagnostic and therapeutic services provided at any medical, surgical, obstetrical, psychiatric and chemical dependency facility, as well as other locations such as laboratories, radiology facilities, provider offices and patient homes.

Authorized representative means an insured's guardian, conservator, holder of a power of attorney, health care agent designated pursuant to M.G.L. c.210, family member, or other

person authorized by the insured in writing or by law with respect to a specific grievance or external review provided that if the insured is unable to designate a representative, where such designation would otherwise be required, a conservator, holder of a power of attorney, or family member in that order of priority may be the insured's representative or appoint another responsible party to serve as the insured's authorized representative.

Bureau of Managed Care or Bureau, the bureau in the Division of Insurance established by M.G.L. c. 176O, § 2.

Capitation, a set payment per patient per unit of time made by a carrier to a licensed health care professional, health care provider group or organization that employs or utilizes services of health care professionals to cover a specified set of services and administrative costs without regard to the actual number of services provided.

Carrier, an insurer licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a nonprofit medical service corporation organized under M.G.L. c. 176B; a health maintenance organization organized under M.G.L. c. 176G; and an organization entering into a preferred provider arrangement under M.G.L. c. 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer. Carrier shall not include any entity to the extent it offers a policy, certificate or contract that provides coverage solely for dental care services or vision care services.

Case management, a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

Clinical peer reviewer, a physician or other health care professional, other than the physician or other health care professional who made the initial decision, who holds a nonrestricted license from the appropriate professional licensing board in Massachusetts, current board certification from a specialty board approved by the American Board of Medical Specialties or of the Advisory Board of Osteopathic Specialists from the major areas of clinical services or, for non-physician health care professionals, the recognized professional board for their specialty, who actively practices in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and whose compensation does not directly or indirectly depend upon the quantity, type or cost of the services that such person approves or denies.

Clinical review criteria, the written screening procedures, decisions, abstracts, clinical protocols and practice guidelines used by a carrier to determine the medical necessity and appropriateness of health care services.

Commissioner, the Commissioner of Insurance, appointed pursuant to M.G.L. c. 26 §6 or his or her designee.

Complaint, (1) any inquiry made by or on behalf of an insured to a carrier or utilization review organization that is not explained or resolved to the insured's satisfaction within

three business days of the inquiry; or (2) any matter concerning an adverse determination. In the case of a carrier or utilization review organization that does not have an internal inquiry process, a complaint means any inquiry.

Concurrent review, utilization review conducted during an insured's inpatient hospital stay or course of treatment.

Covered benefits or benefits, health care services to which an insured is entitled under the terms of the health benefit plan.

Days, calendar days unless otherwise specified in 211 CMR 52.00; provided, that computation of days specified in 211 CMR 52.00 begins with the first day following the referenced action, and provided further that if the final day of a period specified in 211 CMR 52.00 falls on a Saturday, Sunday or state holiday, the final day of the period will be deemed to occur on the next working day.

Discharge planning, the formal process for determining, prior to discharge from a facility, the coordination and management of the care that an insured receives following discharge from a facility.

Division, the Division of Insurance.

Emergency medical condition, a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in § 1867(e)(l)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

Evidence of coverage, any certificate, contract or agreement of health insurance including riders, amendments, endorsements and any other supplementary inserts or a summary plan description pursuant to § 104(b)(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1024(b), issued to an insured specifying the benefits to which the insured is entitled. For workers' compensation preferred provider arrangements, the evidence of coverage will be considered to be the information annually distributed pursuant to 211 CMR 112.04(1)(k).

Facility, a licensed institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

Finding of neglect, a written determination by the Commissioner that a carrier has failed to make and file the materials required by M.G.L. c. 176O or 211 CMR 52.00 in the form and within the time required.

Grievance, any oral or written complaint submitted to the carrier that has been initiated by an insured, or the insured's authorized representative, concerning any aspect or action of the carrier relative to the insured, including, but not limited to, review of adverse determinations regarding scope of coverage, denial of services, quality of care and administrative operations, in accordance with the requirements of M.G.L. c. 176O and 105 CMR 128.000 *et seq*.

HMO, a health maintenance organization licensed pursuant to M.G.L. c. 176G.

Health benefit plan, a policy, contract, certificate or agreement of insurance entered into, offered or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

Health care professional, a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with law.

Health care provider or provider, a health care professional or facility.

Health care services, services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

Incentive plan, any compensation arrangement between a carrier and licensed health care professional or licensed health care provider group or organization that employs or utilizes services of one or more licensed health care professionals that may directly or indirectly have the effect of reducing or limiting specific services furnished to insureds of the organization. "Incentive plan" shall not mean contracts that involve general payments such as capitation payments or shared risk agreements that are made with respect to physicians or physician groups or which are made with respect to groups of insureds if such contracts, which impose risk on such physicians or physician groups for the costs of medical care, services and equipment provided or authorized by another physician or health care provider, comply with 211 CMR 52.00.

Inquiry, any communication by or on behalf of an insured to the carrier or utilization review organization that has not been the subject of an adverse determination and that requests redress of an action, omission or policy of the carrier.

Insured, an enrollee, covered person, insured, member, policy holder or subscriber of a carrier, including an individual whose eligibility as an insured of a carrier is in dispute or under review, or any other individual whose care may be subject to review by a utilization review program or entity as described under the provisions of M.G.L. c. 176O, 211 CMR 52.00 and 105 CMR 128.000.

JCAHO, the Joint Commission on Accreditation of Healthcare Organizations.

Licensed health care provider group, a partnership, association, corporation, individual practice association, or other group that distributes income from the practice among members. An individual practice association is a licensed health care provider group only if it is composed of individual health care professionals and has no subcontracts with licensed health care provider groups.

Limited health service, dental care services, vision care services, pharmaceutical services, and such other services as may be determined by the Commissioner to be limited health services. Limited health service shall not include hospital, medical, surgical or emergency services except as such services are provided in conjunction with the limited health services set forth in the preceding sentence.

Managed care organization or MCO, a carrier subject to M.G.L. c. 176O.

Material change, a modification to any of a carrier's procedures or documents required by 211 CMR 52.00 that substantially affects the rights or responsibilities of an insured, carrier or health care provider.

Medical necessity or medically necessary, health care services that are consistent with generally accepted principles of professional medical practice as determined by whether:
(a) the service is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual;
(b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
(c) for services and interventions not in widespread use, is based on scientific evidence.

National accreditation organization, JCAHO, NCQA, URAC, or any other national accreditation entity approved by the Division that accredits carriers that are subject to the provisions of M.G.L. c. 176O and 211 CMR 52.00.

Network, a grouping of health care providers who contract with a carrier or affiliated carriers to provide services to insureds covered by any or all of the carrier's or affiliated carrier's plans, policies, contracts or other arrangements. Network shall not mean those participating providers who provide services to subscribers of a nonprofit hospital service corporation organized under M.G.L. c. 176A, or a nonprofit medical service corporation organized under M.G.L. c. 176B.

NCQA, the National Committee for Quality Assurance.

Nongatekeeper preferred provider plan, an insured preferred provider plan approved for offer under M.G.L. c.176I which offers preferred benefits when a covered person receives care from preferred network providers but does not require the insured to designate a primary care provider to coordinate the delivery of care or receive referrals from the carrier or any network provider as a condition of receiving benefits at the preferred benefit level.

Office of Patient Protection, the office in the Department of Public Health established by M.G.L. c. 111, § 217(a).

Participating provider, a provider who, under a contract with the carrier or with its contractor or subcontractor, has agreed to provide health care services to insureds with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the carrier.

Preventive health services, any periodic, routine, screening or other services designed for the prevention and early detection of illness that a carrier is required to provide pursuant to Massachusetts or federal law.

Prospective review, utilization review conducted prior to an admission or a course of treatment and shall include any pre-authorization and pre-certification requirements of a carrier or utilization review organization.

Religious non-medical provider, a provider who provides no medical care but who provides only religious non-medical treatment or religious non-medical nursing care.

Retrospective review, utilization review of medical necessity that is conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

Second opinion, an opportunity or requirement to obtain a clinical evaluation by a health care professional other than the health care professional who made the original recommendation for a proposed health service, to assess the clinical necessity and appropriateness of the initial proposed health service.

Service area, the geographical area as approved by the Commissioner within which the carrier has developed a network of providers to afford adequate access to members for covered health services.

Terminally ill or terminal illness, an illness that is likely, within a reasonable degree of medical certainty, to cause one's death within six months, or as otherwise defined in section 1861(dd)(3)(A) of the Social Security Act, 42 U.S.C. section 1395x(dd)(3)(A).

URAC, the American Accreditation HealthCare Commission/URAC, formerly known as the Utilization Review Accreditation Commission.

Utilization review, a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

Utilization review organization, an entity that conducts utilization review under contract with or on behalf of a carrier, but does not include a carrier performing utilization review for its own health benefit plans.

52.04: Accreditation of Carriers

(1) A carrier must be accredited according to the requirements set forth in 211 CMR 52.00 in order to offer for sale, provide, or arrange for the provision of a defined set of health care services to insureds through affiliated and contracting providers or employ utilization review in making decisions about whether services are covered benefits under a health benefit plan.

(2) Accreditation granted to carriers pursuant to 211 CMR 52.00 shall remain in effect for 12 months unless revoked or suspended by the Commissioner.

(3) A carrier shall be exempt from 211 CMR 52.00 if in the written opinion of the Attorney General, the Commissioner of Insurance and the Commissioner of Public Health, the health and safety of health care consumers would be materially jeopardized by requiring accreditation of the carrier.

(a) Before publishing a written exemption pursuant to 211 CMR 52.04(3), the Attorney General, the Commissioner of Insurance and the Commissioner of Public Health shall jointly hold at least one public hearing at which testimony from interested parties on the subject of the exemption shall be solicited.

(b) A carrier granted an exemption pursuant to 211 CMR 52.04(3) shall be provisionally accredited and, during such provisional accreditation, shall be subject to review not less than every four months and shall be subject to those requirements of M.G.L. c. 176O and 211 CMR 52.00 as deemed appropriate by the Commissioner.

(c) Before the end of each four-month period specified in 211 CMR 52.04(3)(b) the Commissioner shall review the carrier's exemption.

1. If the Bureau determines that the carrier has met the requirements of 211 CMR 52.00, then the carrier shall be accredited and the exemption shall expire upon accreditation.
2. If the Commissioner determines that the carrier's exemption should be continued, the Commissioner shall communicate that determination in writing to the Attorney General and the Commissioner of Public Health. Continuation of the exemption shall be granted only upon a written decision by the Commissioner, the Attorney General and the Commissioner of Public Health.

52.05: Deemed Accreditation

(1) A carrier may apply for deemed accreditation. A carrier that applies for deemed accreditation may be deemed to be in compliance with the standards set forth in 211 CMR 52.00 and may be so accredited by the Bureau if it meets the following requirements:

(a) It must be accredited by JCAHO, NCQA or URAC;

(b) It must meet all the requirements set forth in M.G.L. c. 176O, 211 CMR 52.00 and 105 CMR 128.000; and
(c) It must have received the ratings specified in 211 CMR 52.06(5)(e).

(2) For a carrier that applies for deemed accreditation,
(a) If the carrier meets or exceeds the ratings identified in 211 CMR 52.06(5)(c), the carrier shall not be further reviewed by the Bureau for compliance with the standards set forth in 211 CMR 52.08 and 211 CMR 52.09 for that applicable period.
(b) If the carrier meets or exceeds the ratings identified in 211 CMR 52.06(5)(d), the carrier shall not be further reviewed by the Bureau for compliance with the standards set forth in 211 CMR 52.10 for that applicable period.
(c) If the carrier meets or exceeds the ratings identified in 211 CMR 52.06(5)(e), the carrier shall not be further reviewed by the Bureau for compliance with the standards set forth in 211 CMR 52.11 for that applicable period.

(3) A carrier shall not be eligible for deemed accreditation status if the national accreditation organization has revoked the carrier's accreditation status in the past twelve months or the accreditation status of an entity that currently contracts with the carrier to provide services regulated by M.G.L. c. 176O.

(4) A carrier that has applied for deemed accreditation and that has been denied deemed accreditation shall be considered as an applicant for accreditation under 211 CMR 52.06(3) or 211 CMR 52.06(4). Denial of a request for deemed accreditation shall not be eligible for reconsideration under 211 CMR 52.07(5).

(5) If a carrier has received accreditation from a national accreditation organization or a carrier's subcontracting organization, with whom the carrier has a written agreement delegating certain services, has received accreditation or certification from a national accreditation organization, but under standards other than those identified in 211 CMR 52.06(5), the carrier may submit the documents indicating such accreditation or certification so that the Division may consider this in developing the scores described in 211 CMR 52.07(1).

52.06: Application for Accreditation

(1) Timing of application.

(a) Beginning with renewal applications effective after August 1, 2002, carriers must submit renewal applications by July 1 for renewals to be effective on November 1 1.

(b) A carrier seeking initial accreditation after January 1, 2001 must submit an application at least 90 days prior to the date on which it intends to offer health benefit plans.

(2) Inapplicability of accreditation requirements.

(a) A carrier that provides coverage for limited health services only, that does not provide services through a network or through participating providers, or for which other requirements set forth in 52.06 are otherwise inapplicable may indicate within its application which of those items are inapplicable to its health benefit plan and provide an explanation of why the carrier is exempt from each particular requirement.

(b) A carrier that provides coverage for specified services through a workers' compensation preferred provider arrangement may provide evidence of compliance with 211 CMR 112.00 and 452 CMR 6.00 to satisfy the materials required by 211 CMR 52.06(3)(b),(e),(g),(h),(i),(j),(l), and (n). A carrier that provides coverage for specified services through a workers' compensation preferred provider arrangement may provide evidence of compliance with 211 CMR 112.00 and 452 CMR 6.00 to satisfy the materials required by 211 CMR 52.06(4)(d) and (g).

(3) Initial Application. Any carrier seeking initial accreditation under M.G.L. c. 176O must submit an application that contains at least the materials applicable for Massachusetts described in 211 CMR 52.06(3)(a) through (p) in a format specified by the Commissioner. Any carrier that contracts with another organization to perform any of the functions specified in 211 CMR 52.00 is responsible for collecting and submitting all of the materials from the contracting organization.

(a) A filing fee of $500 made payable to the Commonwealth of Massachusetts:

(b) A complete description of the carrier's utilization review policies and procedures;

(c) A written attestation to the Commissioner that the utilization review program of the carrier or its designee complies with all applicable state and federal laws concerning confidentiality and reporting requirements;

(d) A copy of the most recent existing survey described in 211 CMR 52.08(9);

(e) A complete description of the carrier's internal grievance procedures consistent with 105 CMR 128.200 through 128.313 and the external review process consistent with 105 CMR 128.400 through 401;

(f) A complete description of the carrier's process to establish guidelines for medical necessity consistent with 105 CMR 128.101;

(g) A complete description of the carrier's quality management and improvement policies and procedures;

(h) A complete description of the carrier's credentialing policies and procedures.

(i) A complete description of the carrier's policies and procedures for providing or arranging for the provision of preventive health services;

(j) A sample of every provider contract used by the carrier or the organization with which the carrier contracts;
(k) A statement that advises the Bureau whether or not the carrier has issued new contracts, revised existing contracts, or after July 1, 2001, made revisions to fee schedules in any existing contract with a physician or physician group that impose financial risk on such physician or physician group for the costs of medical care, services or equipment provided or authorized by another physician or health care provider. If the carrier has made any of the specified changes, the carrier shall identify the contracts in which such changes were made and identify the sections of the contracts that comply with 211 CMR 52.12(4);
(l) A copy of every provider directory used by the carrier;
(m) The evidence of coverage for every product offered by the carrier;
(n) A copy of each disclosure described in 211 CMR 52.14;
(o) A written attestation that the carrier has complied with 211 CMR 52.16; and
(p) Any additional information as deemed necessary by the Commissioner.

(4) Renewal application. Any carrier seeking renewal of accreditation under M.G.L. c. 176O must submit an application that contains at least the materials for Massachusetts described in 211 CMR 52.06(4)(a) through (j) in a format specified by the Commissioner. Any carrier that contracts with another organization to perform any of the functions specified in 211 CMR 52.00 is responsible for collecting and submitting all of the materials from the contracting organization.
(a) A filing fee of $500 made payable to the Commonwealth of Massachusetts;
(b) A written attestation to the Commissioner that the utilization review program of the carrier or its designee complies with all applicable state and federal laws concerning confidentiality and reporting requirements;
(c) A copy of the most recent survey described in 211 CMR 52.08(10);
(d) A sample of every provider contract used by the carrier or the organization with which the carrier contracts since the carrier's most recent accreditation;
(e) A statement that advises the Bureau whether or not the carrier has issued new contracts, revised existing contracts, or after July 1, 2001, made revisions to fee schedules in any existing contract with a physician or physician group that impose financial risk on such physician or physician group for the costs of medical care, services or equipment provided or authorized by another physician or health care provider. If the carrier has made any of the specified changes, the carrier shall identify the contracts in which such changes were made and identify the sections of the contracts that comply with 211 CMR 52.12(4);
(f) The evidence of coverage for every product offered by the carrier that was revised since the carrier's most recent accreditation;
(g) A copy of the most recently revised provider directory used by the carrier;
(h) Material changes to any of the information contained in 211 CMR 52.06(3)(b), (e), (f), (g), (h), (i), and (n);
(i) Evidence satisfactory to the Commissioner that the carrier has complied with 211 CMR 52.16; and
(j) Any additional information as deemed necessary by the Commissioner.

(5) Application for deemed accreditation. A carrier seeking deemed accreditation pursuant to 211 CMR 52.05 shall submit an application that contains the following:

(a) For initial applicants, the information required by 211 CMR 52.06(3).

(b) For renewal applicants, the information required by 211 CMR 52.06(4).

(c) Proof in a form satisfactory to the Commissioner that the carrier has attained:

1. score equal to or above 80% of the standard in effect at the time of the most recent review by NCQA for the accreditation of managed care organizations, in the categories of utilization management, quality management and improvement, and members' rights and responsibilities;
2. a score equal to or above the rating of "accredited" in the categories of utilization management, network management, quality management and member protections for the most recent review of health plan standards by URAC; or
3. for nongatekeeper preferred provider plans, a score equal to or above 80% of the standard in effect at the time of the most recent review by NCQA for the accreditation of preferred provider organizations, in the categories of utilization management, quality management and improvement, and enrollees' rights and responsibilities.
4. for nongatekeeper preferred provider plans, a score equal to or above the rating of "accredited" in the most recent review of health utilization management standards by URAC and a score equal or above the rating of "accredited" in the categories of network management, quality management and member protections for the most recent review of health network standards by URAC..

(d) Proof in a form satisfactory to the Commissioner that the carrier has attained:

1. score equal to or above 80% of the standard in effect at the time of the most recent review by NCQA for the accreditation of managed care organizations, in the category of credentialing and recredentialing;
2. a score equal to or above the rating of "accredited" in the category of provider credentialing for the most recent review of health plan standards by URAC; or
3. for nongatekeeper preferred provider plans, a score equal to or above 80% of the standard in effect at the time of the most recent review by NCQA for the accreditation of preferred provider organizations in the category of credentialing and recredentialing.
4. for nongatekeeper preferred provider plans, a score equal to or above the rating of "accredited" in the category of provider credentialing for the most recent review of health network standards by URAC.

(e) Proof in a form satisfactory to the Commissioner that the carrier has attained:

1. score equal to or above 80% of the standard in effect at the time of the most recent review by NCQA for the accreditation of managed care organizations, in the category of preventive health services;
2. a score equal to or above the rating of "accredited" in comparable categories for the most recent review of health plan standards by URAC; or
3. a score equal to or above the rating of "accredited" in comparable categories for the most recent review of health plan standards by URAC; or

4. for nongatekeeper preferred provider plans, proof in a form satisfactory to the Commissioner that the carrier satisfies the standards identified in 211 CMR 52.113..

(6) Application to be reviewed as a nongatekeeper preferred provider plan. A carrier shall submit a statement signed by a corporate officer certifying that none of the carrier's insured plans require the insured to designate a primary care provider to coordinate the delivery of care or receive referrals from the carrier or any network provider as a condition of receiving benefits at the preferred benefit level.

(7) Material changes. Carriers shall submit material changes to any of the items required by 211 CMR 52.06(3) and 211 CMR 52.06(4) to the Bureau at least 30 days before the effective date of the changes.

52.07: Review of Application for Accreditation

(1) The Bureau shall review all applications for accreditation according to the standards set forth in M.G.L. c. 176O, 211 CMR 52.00 and 105 CMR 128.000.

(a) For all products, except nongatekeeper preferred provider plans, a carrier shall not be accredited unless the carrier scores 65 percent or higher of the points described in Appendix E: 211 CMR 52.104 for those requirements applicable to that carrier's health plans..

(b) For nongatekeeper preferred provider plans, a carrier shall not be accredited unless the carrier scores 65 percent or higher of the points described in Appendix J: 211 CMR 52.114 for those requirements applicable to that carrier's health plans.

(c) In reviewing the carrier's application for accreditation under 211 CMR 52.07, the carrier may be given credit toward the relevant score for any accreditation that it received separately or a ~~carrier's~~ subcontracting organization, with whom the carrier has a written agreement delegating certain services, has received accreditation or certification from a national accreditation organization for the standards described in 211 CMR 52.08, 211 CMR 52.09, 211 CMR 52.10 or 211 CMR 52.11.

(2) A carrier's application will not be considered to be complete until all materials required by M.G.L. c. 176O and 211 CMR 52.00 have been received by the Bureau. A carrier shall respond to any request for additional information by the Bureau within 15 days of the date of the Bureau's request. A carrier that fails to respond in writing to requests within the 15 days shall be subject to the penalties described in 211 CMR 52.17.

(3) The Bureau may schedule, at the carrier's expense, on-site surveys of the carrier's utilization review, quality management and improvement, credentialing and preventive health services activities in order to examine records. Any on-site visit shall be scheduled within 15 days of receipt of a carrier's complete application.

(4) The Bureau shall notify a carrier in writing that it is accredited or that its application for accreditation has been denied. If an accreditation is denied, the Bureau shall identify those items that require improvement in order to comply with accreditation standards.

(5) Reconsideration of a denial.

(a) A carrier whose application for accreditation has been denied may make a written request to the Bureau for reconsideration within 10 days of receipt of the Bureau's notice.

(b) The Bureau shall schedule a meeting with the carrier within 10 days of the receipt of the request for reconsideration to review any additional materials presented by the carrier.

(c) Following the meeting pursuant to 211 CMR 52.07(5)(b) the Bureau may conduct a second on-site survey at the expense of the carrier.

(d) The Bureau shall notify a carrier in writing of the final disposition of its reconsideration.

52.08: Standards for Utilization Review

(1) A carrier's application will be reviewed for compliance with those NCQA accreditation standards as set forth in Appendix A: 211 CMR 52.100. Nongatekeeper preferred provider plan products will be reviewed for compliance with those NCQA accreditation standards as set forth in Appendix F: 211 CMR 52.110. In addition, carriers shall meet the requirements identified in 211 CMR 52.08(2) through (10). In cases where the standards in 211 CMR 52.08(2) through (10) differ from those in 211 CMR 52.100, the standards in 211 CMR 52.08(2) through (10) shall apply.

(2) Utilization review conducted by a carrier or utilization review organization shall be conducted pursuant to a written plan, under the supervision of a physician and staffed by appropriately trained and qualified personnel, and shall include a documented process to

(a) review and evaluate its effectiveness,

(b) ensure the consistent application of utilization review criteria, and

(c) ensure the timeliness of utilization review determinations.

(3) A carrier or utilization review organization shall adopt utilization review criteria and conduct all utilization review activities pursuant to said criteria.

(a) The criteria shall be, to the maximum extent feasible, scientifically derived and evidence-based, and developed with the input of participating physicians, consistent with the development of medical necessity criteria consistent with 105 CMR 128.101.

(b) Utilization review criteria shall be applied consistently by a carrier or utilization review organization.

(c) Adverse determinations rendered by a program of utilization review, or other denials of requests for health services, shall be made by a person licensed in the appropriate specialty related to such health service and, where applicable, by a provider in the same licensure category as the ordering provider, and shall explain the reason for any denial, including the specific utilization review criteria or benefits provisions used in the determination, and all appeal rights applicable to the denial.

(4) Initial determination regarding a proposed admission, procedure or service. A carrier or utilization review organization shall make an initial determination regarding a proposed admission, procedure or service that requires such a determination within two working days of obtaining all necessary information.

(a) For purposes of 211 CMR 52.08(4), "necessary information" shall include the results of any face-to-face clinical evaluation or second opinion that may be required.

(b) In the case of a determination to approve an admission, procedure or service, the carrier or utilization review organization shall notify the provider rendering the service by telephone within 24 hours, and shall send written or electronic confirmation of the telephone notification to the insured and the provider within two working days thereafter.

(c) In the case of an adverse determination, the carrier or utilization review organization shall notify the provider rendering the service by telephone within 24 hours, and shall send written or electronic confirmation of the telephone notification to the insured and the provider within one working day thereafter.

(5) Concurrent review. A carrier or utilization review organization shall make a concurrent review determination within one working day of obtaining all necessary information.

(a) In the case of a determination to approve an extended stay or additional services, the carrier or utilization review organization shall notify the provider rendering the service by telephone within one working day, and shall send written or electronic confirmation to the insured and the provider within one working day thereafter. A written or electronic notification shall include the number of extended days or the next review date, the new total number of days or services approved, and the date of admission or initiation of services.

(b) In the case of an adverse determination, the carrier or utilization review organization shall notify the provider rendering the service by telephone within 24 hours, and shall send written or electronic notification to the insured and the provider within one working day thereafter. The service shall be continued without liability to the insured until the insured has been notified of the determination.

(6) Written notice. The written notification of an adverse determination shall include a substantive clinical justification therefor that is consistent with generally accepted principles of professional medical practice, and shall, at a minimum:

(a) identify the specific information upon which the adverse determination was based;

(b) discuss the insured's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;

(c) specify any alternative treatment option offered by the carrier, if any;

(d) reference and include applicable clinical practice guidelines and review criteria; and

(e) include a clear, concise and complete description of the carrier’s formal internal grievance process and the procedures for obtaining external review pursuant to 105 CMR 128.400.

(7) Reconsideration of an adverse determination. A carrier or utilization review organization shall give a provider treating an insured an opportunity to seek reconsideration of an adverse determination from a clinical peer reviewer in any case involving an initial determination or a concurrent review determination.

(a) The reconsideration process shall occur within one working day of the receipt of the request and shall be conducted between the provider rendering the service and the clinical peer reviewer or a clinical peer designated by the clinical peer reviewer if the reviewer cannot be available within one working day.

(b) If the adverse determination is not reversed by the reconsideration process, the insured, or the provider on behalf of the insured, may pursue the grievance process established pursuant to 105 CMR 128.000.

(c) The reconsideration process allowed pursuant to 211 CMR 52.08(6) shall not be a prerequisite to the internal grievance process or an expedited appeal required by 105 CMR 128.000.

(8) Continuity of care. A carrier must provide evidence that its policies regarding continuity of care comply with all provisions of 105 CMR 128.500 through 128.503.

(9) A carrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR 52.08, except 211 CMR 52.08(9), if it has met the requirements of 452 CMR 6.00.

(10) A carrier or utilization review organization shall conduct an annual survey of insureds to assess satisfaction with access to specialist services, ancillary services, hospitalization services, durable medical equipment and other covered services.

(a) The survey shall compare the actual satisfaction of insureds with projected measures of their satisfaction.

(b) Carriers that utilize incentive plans shall establish mechanisms for monitoring the satisfaction, quality of care and actual utilization compared with projected utilization of health care services of insureds.

(11) Nothing in 211 CMR 52.08 shall be construed to require health benefit plans to use medical professionals or criteria to decide insured access to religious non-medical providers, utilize medical professionals or criteria in making decisions in internal appeals from decisions denying or limiting coverage or care by religious non-medical providers, compel an insured to undergo a medical examination or test as a condition of receiving coverage for treatment by a religious non-medical provider, or require health benefit plans to exclude religious non-medical providers because they do not provide medical or other data otherwise required, if such data is inconsistent with the religious non-medical treatment or nursing care provided by the provider.

52.09: Standards for Quality Management and Improvement

(1) A carrier's application will be reviewed for compliance with those NCQA accreditation standards as set forth in Appendix B: 211 CMR 52.101. Nongatekeeper preferred provider plan products will be reviewed for compliance with those NCQA accreditation standards set forth in Appendix G: 211 CMR 52.111.

(2) A carrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR 52.09 if it has met the requirements of 452 CMR 6.00.

52.10: Standards for Credentialing

(1) A carrier's application will be reviewed for compliance with those NCQA accreditation standards as set forth in Appendix C: 211 CMR 52.102. Nongatekeeper preferred provider plan products will be reviewed for compliance with those NCQA accreditation standards set forth in Appendix H: 211 CMR 52.112.
(2) A carrier shall provide a written reason or reasons for denial to health care providers whose applications to be participating providers were denied.
(3) A carrier shall not be required to meet the requirements of 211 CMR 52.10 if the carrier does not provide benefits through a network or does not have contracts with participating providers.
(4) A carrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR 52.10 if it has met the requirements of 211 CMR 112.00 and 452 CMR 6.00.

52.11: Standards for Preventive Health Services

(1) A carrier shall provide coverage for those preventive services mandated by applicable law. A carrier that is not an HMO shall be required to comply with 211 CMR 52.11 only to the extent of those preventive health services mandated by its licensing or enabling statute.
(2) A carrier's application will be reviewed for compliance with those NCQA accreditation standards as set forth in Appendix D: 211 CMR 52.103. Nongatekeeper preferred provider plan products will be reviewed for compliance with those NCQA accreditation standards set forth in Appendix I: 211 CMR 52.113.
(3) A carrier that provides specified services through a workers' compensation preferred provider arrangement shall not be required to meet the requirements of 211 CMR 52.11.

52.12: Standards for Provider Contracts

(1) Contracts between carriers and health care providers shall state that a carrier shall not refuse to contract with or compensate for covered services an otherwise eligible health care provider solely because such provider has in good faith:

(a) communicated with or advocated on behalf of one or more of his prospective, current or former patients regarding the provisions, terms or requirements of the carrier's health benefit plans as they relate to the needs of such provider's patients; or
(b) communicated with one or more of his prospective, current or former patients with respect to the method by which such provider is compensated by the carrier for services provided to the patient.

(2) Contracts between carriers and health care providers shall state that the provider is not required to indemnify the carrier for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the carrier based on the carrier's management decisions, utilization review provisions or other policies, guidelines or actions.

(3) No contract between a carrier and a licensed health care provider group may contain any incentive plan that includes a specific payment made to a health care professional as an inducement to reduce, delay or limit specific, medically necessary services covered by the health care contract.

(a) Health care professionals shall not profit from provision of covered services that are not medically necessary or medically appropriate.

(b) Carriers shall not profit from denial or withholding of covered services that are medically necessary or medically appropriate.

(c) Nothing in 211 CMR 52.12(3) shall be construed to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or shared risk agreements that are made with respect to physicians or physician groups or which are made with respect to groups of insureds if such contracts, which impose risk on such physicians or physician groups for the costs of medical care, services and equipment provided or authorized by another physician or health care provider, comply with 211 CMR 52.12(4).

(4) No carrier may enter into a new contract, revise the risk arrangements in an existing contract, or after July 1, 2001, revise the fee schedule in an existing contract with a physician or physician group which imposes financial risk on such physician or physician group for the costs of medical care, services or equipment provided or authorized by another physician or health care provider unless such contract includes specific provisions with respect to the following:

(a) stop loss protection,

(b) minimum patient population size for the physician or physician group, and

(c) identification of the health care services for which the physician or physician group is at risk.

(5) Contracts between carriers and health care providers shall state that neither the carrier nor the provider has the right to terminate the contract without cause.

(6) Contracts between carriers and health care providers shall state that a carrier shall provide a written statement to a provider of the reason or reasons for such provider's involuntary disenrollment.

(7) Contracts between carriers and health care providers shall state that the carrier shall notify providers in writing of modifications in payments, modifications in covered services or modifications in a carrier’s procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of the providers, and the effective date of the modifications. The notice shall be provided 60 days before the effective date of such modification unless such other date for notice is mutually agreed upon between the carrier and the provider.

(8) Contracts between carriers and health care providers shall state that providers shall not bill patients for charges for covered services other than for deductibles, copayments, or coinsurance.

(9) Contracts between carriers and health care providers shall prohibit health care providers from billing patients for nonpayment by the carrier of amounts owed under the contract due to the insolvency of the carrier. Contracts shall further state that this requirement shall survive the termination of the contract for services rendered prior to the termination of the contract, regardless of the cause of the termination.

(10) Contracts between carriers and health care providers shall require providers to comply with the carrier's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services.
(11) Nothing in 211 CMR 52.12 shall be construed to preclude a carrier from requiring a health care provider to hold confidential specific compensation terms.
(12) Nothing in 211 CMR 52.12 shall be construed to restrict or limit the rights of health benefit plans to include as providers religious non-medical providers or to utilize medically based eligibility standards or criteria in deciding provider status for religious non-medical providers.

52.13: Evidences of Coverage

(1) A carrier shall issue and deliver to at least one adult insured in each household residing in Massachusetts, upon enrollment, an evidence of coverage. The evidence of coverage shall contain a clear, concise and complete statement of:

(a) the health care services and any other benefits to which the insured is entitled on a nondiscriminatory basis, including benefits mandated by state or federal law;
(b) the prepaid fee which must be paid by or on behalf of the insured and an explanation of any grace period for the payment of any premium;
(c) the limitations on the scope of health care services and any other benefits to be provided, including an explanation of any deductible or copayment feature;
(d) all restrictions relating to preexisting condition limitations or exclusions, or a statement that there are no preexisting condition limitations or exclusions if there are none under the health benefit plan;
(e) the locations where, and the manner in which, health care services and other benefits may be obtained;
(f) a description of eligibility of coverage for dependents, including a summary description of the procedure by which dependents may be added to the plan;
(g) the criteria by which an insured may be disenrolled or denied enrollment;
(h) the involuntary disenrollment rate among insureds of the carrier;

1. For the purposes of 211 CMR 52.13(1)(h), carriers shall exclude all administrative disenrollments, insureds who are disenrolled because they have moved out of a health plan's service area, insureds whose continuation of coverage periods have expired, former dependents who no longer qualify as dependents, or insureds who lose coverage under an employer-sponsored plan because they have ceased employment or because their employer group has cancelled coverage under the plan, reduced the numbers of hours worked, become disabled, retired or died.
2. For the purposes of 211 CMR 52.13(1)(h), the term "involuntary disenrollment" means that a carrier has terminated the coverage of the insured due to any of the reasons contained in 211 CMR 52.13(1)(i)2. and 3.

(i) the requirement that an insured's coverage may be canceled, or its renewal refused, only in the following circumstances:

1. failure by the insured or other responsible party to make payments required under the contract;
2. misrepresentation or fraud on the part of the insured;
3. commission of acts of physical or verbal abuse by the insured which pose a threat to providers or other insureds of the carrier and which are unrelated to the physical or mental condition of the insured; provided, that the commissioner prescribes or approves the procedures for the implementation of the provisions of this clause;
4. relocation of the insured outside the service area of the carrier; or
5. non-renewal or cancellation of the group contract through which the insured receives coverage;

(j) a description of the carrier's method for resolving insured inquiries and complaints, including a description of the internal grievance process consistent with 105 CMR 128.300 through 128.313, and the external review process consistent with 105 CMR 128.400 through 128.416;

(k) a statement telling insureds how to obtain the report regarding grievances pursuant to 105 CMR 128.600(A)(4) from the Office of Patient Protection;

(l) a description of the Office of Patient Protection, including its toll-free telephone number, facsimile number, and internet site;

(m) a summary description of the procedure, if any, for out-of-network referrals and any additional charge for utilizing out-of-network providers;

(n) a summary description of the utilization review procedures and quality assurance programs used by the carrier, including the toll-free telephone number to be established by the carrier that enables consumers to determine the status or outcome of utilization review decisions;

(o) a statement detailing what translator and interpretation services are available to assist insureds, including that the carrier will provide, upon request, interpreter and translation services related to administrative procedures. The statement must appear in at least Arabic, Cambodian, Chinese, English, French, Greek, Haitian-Creole, Italian, Lao, Portuguese, Russian and Spanish;

(p) a list of prescription drugs excluded from any closed or restricted formulary available to insureds under the health benefit plan; provided, that the carrier shall annually disclose any changes in such a formulary, and shall provide a toll-free telephone number to enable consumers to determine whether a particular drug is included in the closed or restricted formulary.

1. A carrier will be deemed to have met the requirements of 211 CMR 52.13(1)(p) if the carrier does all of the following:
   a. provides a complete list of prescription drugs that are included in any closed or restricted formulary;
   b. clearly states that all other prescription drugs are excluded;
   c. provides a toll-free number that is updated within 48 hours of any change in the closed or restricted formulary to enable insureds to determine whether a particular drug is included in or excluded from the closed or restricted formulary; and
   d. provides an internet site that is updated as soon as practicable relative to any change in the closed or restricted formulary to enable insureds to determine whether a particular drug is

included in or excluded from the closed or restricted formulary;

(q) a summary description of the procedures followed by the carrier in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials;

(r) requirements for continuation of coverage mandated by state and federal law;

(s) a description of coordination of benefits consistent with 211 CMR 38.00;

(t) a description of coverage for emergency care and a statement that insureds have the opportunity to obtain health care services for an emergency medical condition, including the option of calling the local pre-hospital emergency medical service system, whenever the insured is confronted with an emergency medical condition which in the judgment of a prudent layperson would require pre-hospital emergency services;

(u) If the carrier offers services through a network or through participating providers, the following statements regarding continued treatment:

1. If the carrier allows or requires the designation of a primary care physician, a statement that the carrier will notify an insured at least 30 days before the disenrollment of such insured's primary care physician and shall permit such insured to continue to be covered for health services, consistent with the terms of the evidence of coverage, by such primary care physician for at least 30 days after said physician is disenrolled, other than disenrollment for quality related reasons or for fraud. The statement shall also include a description of the procedure for choosing an alternative primary care physician.

2. A statement that the carrier will allow any female insured who is in her second or third trimester of pregnancy and whose provider in connection with her pregnancy is involuntarily disenrolled, other than disenrollment for quality-related reasons or for fraud, to continue treatment with said provider, consistent with the terms of the evidence of coverage, for the period up to and including the insured's first postpartum visit.

3. A statement that the carrier will allow any insured who is terminally ill and whose provider in connection with said illness is involuntarily disenrolled, other than disenrollment for quality related reasons or for fraud, to continue treatment with said provider, consistent with the terms of the evidence of coverage, until the insured's death.

4. A statement that the carrier will provide coverage for health services for up to 30 days from the effective date of coverage to a new insured by a physician who is not a participating provider in the carrier's network if:

a. the insured's employer only offers the insured a choice of carriers in which said physician is not a participating provider, and

b. said physician is providing the insured with an ongoing course of treatment or is the insured's primary care physician.

c. With respect to an insured in her second or third trimester of pregnancy, this provision shall apply to services rendered through the first postpartum visit. With respect to an insured with a terminal illness, this provision shall apply to services rendered until death.

5. A carrier may condition coverage of continued treatment by a provider under 211 CMR 52.13(1)(u)1. through 4., inclusive, upon the provider's agreeing

a. to accept reimbursement from the carrier at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to the insured in an amount that would exceed the cost sharing that could have been imposed if the provider had not been disenrolled;

b. to adhere to the quality assurance standards of the carrier and to provide the carrier with necessary medical information related to the care provided; and

c. to adhere to the carrier's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing services pursuant to a treatment plan, if any, approved by the carrier.

6. Nothing in 211 CMR 52.13(1)(u) shall be construed to require the coverage of benefits that would not have been covered if the provider involved remained a participating provider.

(v) If a carrier requires an insured to designate a primary care physician, a statement that the carrier will allow the primary care physician to authorize a standing referral for specialty health care provided by a health care provider participating in the carrier's network when:

1. the primary care physician determines that such referrals are appropriate,

2. the provider of specialty health care agrees to a treatment plan for the insured and provides the primary care physician with all necessary clinical and administrative information on a regular basis, and

3. the health care services to be provided are consistent with the terms of the evidence of coverage.

4. Nothing in 211 CMR 52.13(v) shall be construed to permit a provider of specialty health care who is the subject of a referral to authorize any further referral of an insured to any other provider without the approval of the insured's carrier.

(w) If a carrier requires an insured to obtain referrals or prior authorization from a primary care physician for specialty care, a statement that the carrier will not require an insured to obtain a referral or prior authorization from a primary care physician for the following specialty care provided by an obstetrician, gynecologist, certified nurse midwife or family practitioner participating in such carrier's health care provider network and that the carrier will not require higher copayments, coinsurance, deductibles or additional cost sharing arrangements for such services provided to such insureds in the absence of a referral from a primary care physician:

1. annual preventive gynecologic health examinations, including any subsequent obstetric or gynecological services determined by such obstetrician, gynecologist, certified nurse midwife or family practitioner to be medically necessary as a result of such examination;

2. maternity care; and

3. medically necessary evaluations and resultant health care services for acute or emergency gynecological conditions.
4. Carriers may establish reasonable requirements for participating obstetricians, gynecologists, certified nurse midwives or family practitioners to communicate with an insured's primary care physician regarding the insured's condition, treatment, and need for follow-up care.
5. Nothing in 211 CMR 52.13(1)(w) shall be construed to permit an obstetrician, gynecologist, certified nurse midwife or family practitioner to authorize any further referral of an insured to any other provider without the approval of the insured's carrier.

(x) A statement that the carrier will provide coverage of pediatric specialty care, including, for the purposes of 211 CMR 52.13(1)(x), mental health care, by persons with recognized expertise in specialty pediatrics to insureds requiring such services.

(2) A carrier shall issue and deliver to at least one adult insured in each household residing in Massachusetts, or in the case of a group policy, to the group representative, prior notice of material modifications in covered services under the health plan at least 60 days before the effective date of the modifications. The notices shall include the following:

(a) any changes in clinical review criteria

(b) a statement of the effect of such changes on the personal liability of the insured for the cost of any such changes.

(3) A carrier shall submit all evidences of coverage to the Division at least 30 days prior to their effective dates.

(4) A carrier shall provide to at least one adult insured in each household residing in Massachusetts notice of all material changes to the evidence of coverage.

(5) Carriers may use evidences of coverage issued prior to July 1, 2001, as if in compliance with 211 CMR 52.13. Evidences of coverage issued or renewed on or after July 1, 2001 must comply with all of the requirements of 211 CMR 52.13. Carriers shall issue to at least one adult insured in each household whose coverage renews between July 1, 2001, and June 30, 2002, an evidence of coverage upon renewal that complies with 211 CMR 52.13. Carriers may provide notice of material changes by issuing riders, amendments or endorsements to insureds who have received evidences of coverage in compliance with 211 CMR 52.13, provided, that a completely revised evidence of coverage shall be issued to at least one adult insured in each household residing in Massachusetts at least once every five years.

(6) Every evidence of coverage described in 211 CMR 52.13 must contain the effective date, date of issue and, if applicable, expiration date.

(7) A carrier will be deemed to have met the requirements to issue or deliver an evidence of coverage or any material change to an evidence of coverage to persons enrolled in an employer group plan when sending documents by electronic media, if:

(a) the employer group's insureds have the ability to effectively access documents furnished in electronic form at their worksite location;
(b) the employer group's insureds have the opportunity to readily convert furnished documents from electronic form to paper form free of charge at their worksite location;
(c) the carrier can demonstrate that it has taken appropriate and necessary measures to ensure that the system for furnishing documents results in actual receipt by insureds of the electronically transmitted information and documents (for example, the carrier uses the return-receipt electronic mail features or conducts periodic reviews or surveys to confirm receipt of transmitted information);
(d) the carrier can demonstrate that its electronically delivered documents are prepared and furnished in a manner consistent with that used for its paper documents;
(e) the carrier can demonstrate that the person covered through the employer group is provided notice, through electronic means or in writing, apprising the person of the documents to be furnished electronically, the significance of the documents and the person's right to request and method to receive, free of charge, a paper copy of such document; and
(f) the carrier can demonstrate that it has taken the steps to furnish, upon request of the insured, a paper copy of any document delivered to the insured through electronic media.

(8) A carrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR 52.13 if it has met the requirements of 211 CMR 112.00 and 452 CMR 6.00.

52.14: Required Disclosures

(1) A carrier shall provide to at least one adult insured in each household upon enrollment, and to a prospective insured upon request, the following information:
(a) a statement that physician profiling information, so-called, may be available from the Board of Registration in Medicine for physicians licensed to practice in Massachusetts;
(b) a summary description of the process by which clinical guidelines and utilization review criteria are developed;
(c) the voluntary and involuntary disenrollment rate among insureds of the carrier;
1. For the purposes of 211 CMR 52.14(1)(c), carriers shall exclude all administrative disenrollments, insureds who are disenrolled because they have moved out of a health plan's service area, insureds whose continuation of coverage periods have expired, former dependents who no longer qualify as dependents, or insureds who lose coverage under an employer-sponsored plan because they have ceased employment or because their employer group has cancelled coverage under the plan, reduced the numbers of hours worked, retired or died.

2. For the purposes of 211 CMR 52.14(1)(c), the term "voluntary disenrollment" means that an insured has terminated coverage with the carrier for nonpayment of premium.
3. For the purposes of 211 CMR 52.14(1)(c), the term "involuntary disenrollment" means that a carrier has terminated the coverage of the insured due to any of the reasons contained in 211 CMR 52.13(1)(i)2. and 3.

(d) A notice to insureds regarding emergency medical conditions that states all of the following:

1. that insureds have the opportunity to obtain health care services for an emergency medical condition, including the option of calling the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever the insured is confronted with an emergency medical condition which in the judgment of a prudent layperson would require pre-hospital emergency services;
2. that no insured shall in any way be discouraged from using the local pre-hospital emergency medical service system, the 911 telephone number, or the local equivalent;
3. that no insured will be denied coverage for medical and transportation expenses incurred as a result of such emergency medical condition; and
4. if the carrier requires an insured to contact either the carrier or its designee or the primary care physician of the insured within 48 hours of receiving emergency services, that notification already given to the carrier, designee or primary care physician by the attending emergency physician shall satisfy that requirement.

(e) a description of the Office of Patient Protection and a statement that the information specified in 211 CMR 52.16 is available to the insured or prospective insured from the Office of Patient Protection.

(2) The information required by 211 CMR 52.14 may be contained in the evidence of coverage and need not be provided in a separate document.

(3) Every disclosure described in 211 CMR 52.14 must contain the effective date, date of issue and, if applicable, expiration date.

(4) Carriers shall submit material changes to the disclosures required by 211 CMR 52.14 to the Bureau at least 30 days before their effective dates.

(5) Carriers shall submit material changes to the disclosures required by 211 CMR 52.14 to at least one adult insured in every household residing in Massachusetts at least once every two years.

(6) A carrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR 52.14 if it has met the requirements of 211 CMR 112.00 and 452 CMR 6.00.

52.15: Provider Directories

(1) A carrier shall provide a provider directory to at least one adult insured in each household upon enrollment and to a prospective or current insured upon request.

Annually, thereafter, a carrier shall provide to at least one adult insured in each household, or in the case of a group policy, to the group representative, a provider directory.

(a) The provider directory must contain a list of health care providers in the carrier's network available to insureds residing in Massachusetts, organized by specialty and by location and summarizing for each such provider the method used to compensate or reimburse such provider.

1. Nothing in 211 CMR 52.15(1)(a) shall be construed to require disclosure of the specific details of any financial arrangements between a carrier and a provider.
2. A carrier will be deemed to be in compliance with 211 CMR 52.15(1)(a) if the method of compensation is identified at least as specifically as "fee-for service" or "capitation."
3. If any specific providers or type of providers requested by an insured are not available in said network, or are not a covered benefit, such information shall be provided in an easily obtainable manner.

(b) The provider directory must contain a toll-free number that insureds can call to determine whether a particular health care provider is affiliated with the carrier.

(c) The provider directory must contain an internet website address that insureds can visit to determine whether a particular provider is affiliated with the carrier.

(2) Carriers that issued provider directories prior to January 1, 2001 shall be deemed to have met the requirements of 211 CMR 52.15(1) if during the year between July 1, 2001 and June 30, 2002 the carrier delivers a provider directory to at least one adult insured in each household and to any new enrollee on or after July 1, 2001.

(3) A carrier shall be deemed to have met the requirements of 211 CMR 52.15(1) if the carrier provides to at least one adult insured in each household, or in the case of a group policy, to the group representative, at least once per calendar year an addendum, insert, or other update to the provider directory originally provided under 211 CMR 52.15(1), and updates its toll-free number within 48 hours and internet website as soon as practicable A carrier shall not be required to provide a provider directory upon enrollment if a provider directory is provided to the prospective or current insured, or in the case of a group policy, to the group representative, during applicable open enrollment periods.

(4) Every provider directory described in 211 CMR 52.15 must contain the effective date, date of issue and expiration date if applicable.

(5) A carrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR 52.15 if it has met the requirements of 211 CMR 112.00 and 452 CMR 6.00.

52.16: Material to be Provided to the Office of Patient Protection

A carrier shall provide the following to the Office of Patient Protection by no later than May 15 of each year:

(1) A copy of every evidence of coverage and amendments thereto offered by the carrier.

(2) A copy of the provider directory described in 211 CMR 52.15.

(3) A copy of the materials specified in 211 CMR 52.14.

(4) A list of sources of independently published information assessing insured satisfaction and evaluating the quality of health care services offered by the carrier.
(5) A report of the percentage of physicians who voluntarily and involuntarily terminated participation contracts with the carrier during the previous calendar year for which such data has been compiled and the three most common reasons for voluntary and involuntary physician disenrollment;

(a) For the purposes of 211 CMR 52.16(5) carriers shall exclude physicians who have moved from one physician group to another but are still under contract with the carrier.

(b) For the purposes of 211 CMR 52.16(5) "voluntarily terminated" means that the physician terminated its contract with the carrier.

(c) For the purposes of 211 CMR 52.16(5) "involuntarily terminated" means that the carrier terminated its contract with the physician.

(6) The percentage of premium revenue expended by the carrier for health care services provided to insureds for the most recent year for which information is available; and
(7) A report detailing, for the previous calendar year, the total number of

(a) filed grievances, grievances that were approved internally, grievances that were denied internally, and grievances that were withdrawn before resolution; and

(b) external appeals pursued after exhausting the internal grievance process and the resolution of all such external appeals. The report shall identify for each such category, to the extent such information is available, the demographics of such insureds, which shall include, but need not be limited to, race, gender and age.

(8) A carrier that provides specified services through a workers' compensation preferred provider arrangement shall not be required to meet the requirements of 211 CMR 52.16(1), (2), (3), (6) and (7).

52.17: Noncompliance with 211 CMR 52.00

(1) Reporting. If the Commissioner issues a finding of neglect on the part of a carrier, the Commissioner shall notify the carrier in writing that the carrier has failed to make and file the materials required by M.G.L. c. 176O or 211 CMR 52.00 in the form and within the time required. The notice shall identify all deficiencies and the manner in which the neglect must be remedied. Following the written notice, the Commissioner shall fine the carrier $5000 for each day during which the neglect continues.

(a) Following notice and hearing, the Commissioner shall suspend the carrier's authority to do new business until all required reports or materials are received in a form satisfactory to the Commissioner and the Commissioner has determined that the finding of neglect can be removed.

(2) Noncompliance with accreditation standards set forth in 211 CMR 52.00.

(a) The Bureau shall investigate all complaints made against a carrier or any entity with which it contracts for allegations of noncompliance with the accreditation requirements established under 211 CMR 52.00.

(b) The Bureau shall notify a carrier when, in the opinion of the Bureau, complaints made against a carrier or any entity with which it contracts indicate a pattern of noncompliance with a particular requirement. The notice shall detail the alleged noncompliance and establish a hearing date for the matter.

(c) Hearing held pursuant to 211 CMR 52.17(2)(b).

1. The hearing shall be held no later than 21 days following the date of the notice specified in 211 CMR 52.17(2)(b).
2. The hearing shall be conducted pursuant to M.G.L. c. 30A.
3. The hearing shall provide the carrier with an opportunity to respond to the alleged noncompliance.

(d) Penalties. Following the hearing specified in 211 CMR 52.17(2)(c), the Bureau may issue a finding against the carrier, including but not limited to:

1. An order requesting a corrective action plan and timeframe to achieve compliance.
2. A reprimand or censure of the carrier.
3. A penalty not to exceed $10,000 for each classification of violation.
4. The suspension or revocation of the carrier's accreditation.

(3) Action by a national accreditation organization. If a national accreditation organization takes any action to revoke the accreditation or otherwise limit or negatively affect the accreditation status of a carrier, or any entity with which a carrier contracts for services subject to M.G.L. c. 176O, the carrier must notify the Bureau within two days and shall specify the action taken and the reasons given by the national accreditation organization for such action.

(4) If the national accreditation organization revokes accreditation, the Bureau shall initiate proceedings pursuant to M.G.L. c. 30A to revoke or suspend the carrier's accreditation.

(5) Nothing in 211 CMR 52.17 shall be construed to prohibit the Bureau and a carrier from resolving compliance issues through informal means.

52.18: Severability

If any provision of 211 CMR 52.00 or the applicability thereof to any person, entity or circumstance is held invalid by a court, the remainder of 211 CMR 52.00 or the applicability of such provision to other persons, entities or circumstances shall not be affected thereby.

52.100: Appendix A: Standards for Utilization Management in the NCQA Surveyor Guidelines for the Accreditation of MCOs effective July 1, 2001

UM 1 Utilization Management Structure

The managed care organization's utilization management (UM) structures and processes are clearly defined and responsibility is assigned to appropriate individuals.

UM 1.1 A written description of the UM program outlines the program structure and accountability.

UM 1.1.1 The written description of the UM program specifically addresses the behavioral health care aspects of the program.

UM 1.2 A designated senior physician has substantial involvement in UM program implementation.

UM 1.2.1 A designated behavioral health care practitioner has substantial involvement in the implementation of the behavioral health care aspects of the UM program.

UM 1.3 The description includes the scope of the program and the processes and information sources used to make determinations of benefit coverage and medical necessity.

UM 1.4 The UM program is evaluated and approved annually by senior management or the QI committee. It is updated as necessary.

UM 2 Clinical Criteria for UM Decisions

To make utilization decisions, the managed care organization uses written criteria based on sound clinical evidence and specifies procedures for applying those criteria in an appropriate manner.

UM 2.1 The criteria for determining medical necessity are clearly documented and include procedures for applying criteria based on the needs of individual patients and characteristics of the local delivery system.

UM 2.2 The managed care organization involves appropriate, actively practicing practitioners in its development or adoption of criteria and in the development and review of procedures for applying the criteria.

UM 2.3 The managed care organization reviews the criteria at specified intervals and updates them as necessary.

UM 2.4 The managed care organization states in writing how practitioners can obtain the UM criteria and makes the criteria available to its practitioners upon request.

UM 2.5 At least annually, the managed care organization evaluates the consistency with which the health care professionals involved in utilization review apply the criteria in decision making.

UM 3 Appropriate Professionals

Qualified licensed health professionals assess the clinical information used to support UM decisions.

UM 3.1 Appropriately licensed health professionals supervise all the review decisions.

UM 3.2 An appropriate practitioner reviews any denial of care.

UM 3.2.1 A licensed physician reviews any denial that is based on medical necessity.

UM 3.2.2 A psychiatrist, doctoral-level clinical psychologist, or certified addiction medicine specialist reviews any denial of behavioral health care that is based on medical necessity.

UM 3.3 The managed care organization has written procedures for using board-certified physicians from appropriate specialty areas to assist in making determinations of medical necessity.

UM 4 Timeliness of UM Decisions

The managed care organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation.

UM 4.1 The managed care organization follows NCQA's standards for the timeliness of UM decision making.

UM 4.1.1 For precertifications of nonurgent care, the managed care organization makes decisions within two working days of obtaining all the necessary information.

UM 4.1.2 For precertifications of nonurgent care, the managed care organization notifies practitioners of the decisions within one working day of making the decision.

UM 4.1.3 For precertifications of nonurgent care that result in a denial, the managed care organization gives members and practitioners written or electronic confirmation of the decisions within two working days of making the decision.

UM 4.1.4 For precertifications of urgent care, the managed care organization makes decisions and notifies practitioners of the decisions within one calendar day. If the decision is a denial, the MCO must also notify members within one calendar day.

UM 4.1.5 For precertifications of urgent care that result in a denial, the managed care organization notifies both members and practitioners how to initiate an expedited appeal at the time they are notified of the denial.

UM 4.1.6 For precertifications of urgent care that result in a denial, the managed care organization gives members and practitioners written or electronic confirmation of the decisions within two working days of making the decision.

UM 4.1.7 For concurrent review of services, the managed care organization makes decisions for:

UM 4.1.7.1 inpatient, intensive outpatient and residential behavioral care within one working day of obtaining all the necessary information.

UM 4.1.7.2 ongoing ambulatory care within 10 working days of obtaining all the necessary information.

UM 4.1.8 For concurrent review, the managed care organization notifies practitioners of decisions within one working day of making the decision.

UM 4.1.9 For concurrent review decisions that result in a denial, the managed care organization gives members and practitioners written or electronic confirmation within one working day of the original notification.

UM 4.1.10 For concurrent review decisions that result in a denial, the managed care organization notifies both members and practitioners how to initiate an expedited appeal at the time they are notified of the denial.

UM 4.1.11 For retrospective review, the managed care organization makes the decision within 30 working days of obtaining all the necessary information.

UM 4.1.12 For retrospective review, the managed care organization notifies practitioners and members of denials in writing within five working days of making the decision.

UM 5 Clinical Information

When making a determination of coverage based on medical necessity, the managed care organization obtains relevant clinical information and consults with the treating physician.

UM 5.1 A written description identifies the information that is collected to support UM decision making.

UM 5.2 There is documentation that relevant clinical information is gathered consistently to support UM decision making.

UM 5.3 The managed care organization assists with a member's transition to other care, if necessary, when benefits end.

UM 6 Denial Notices

The managed care organization clearly documents and communicates the reasons for each denial.

UM 6.1 The managed care organization makes available to practitioners a physician reviewer to discuss by telephone determinations based on medical necessity.

UM 6.2 The managed care organization sends written notification to members and practitioners, as appropriate, of the reason for each denial, including the specific utilization review criteria or benefits provisions used in the determination.

UM 6.3 The managed care organization includes information about the appeal process in all denial notifications.

UM 7 Policies for Appeals

The managed care organization has written policies and procedures for the thorough, appropriate and timely resolution of member appeals.

UM 7.1 Procedures for registering and responding to oral and written first-level appeals include the following elements:

UM 7.1.1 notification to the member of the appeal process within five working days of receiving a request for a first-level appeal;

UM 7.1.2 documentation of the substance of the appeal and the actions taken;

UM 7.1.3 full investigation of the substance of the appeal, including any aspects of clinical care involved;

UM 7.1.4 resolution of the appeal, including:

UM 7.1.4.1 The managed care organization appoints a person or people to review the first-level appeal who were not involved in the initial determination.

UM 7.1.4.2 If the managed care organization cannot make a decision within 30 working days due to circumstances beyond its control, the managed care organization issues a written decision within 15 additional working days

and provides notice to the member with the reasons for the delay before the 30th working day.

UM 7.1.5 written notification to the member of the disposition of the appeal and the right to appeal further.

UM 7.1.6 The managed care organization establishes procedures for registering and responding to expedited first-level appeals.

UM 7.1.6.1 An expedited appeal may be initiated by the member or by a practitioner acting on behalf of the member.

UM 7.1.6.2 The managed care organization makes the expedited appeal decision and notifies the member and practitioner(s) as expeditiously as the medical condition requires, but no later than three calendar days after the request is made.

UM 7.1.6.3 The managed care organization provides written confirmation of its decisions within two working days of providing notification of that decision, if the initial decision was not in writing.

UM 7.2 Procedures for registering and responding to oral and written second-level appeals include the following elements:

UM 7.2.1 documentation of the substance of the appeal and the actions taken;

UM 7.2.2 full investigation of the substance of the appeal, including any aspects of clinical care involved;

UM 7.2.3 resolution of the appeal, including:

UM 7.2.3.1 The managed care organization appoints a panel for the second-level review composed of representatives not involved in any previous decisions regarding the appeal.

UM 7.2.3.2 The member has a right to appear before the panel. A member who cannot appear in person at the panel hearing is provided the opportunity to communicate with the panel by conference call or other appropriate technology and

UM 7.2.3.3 The managed care organization resolves second-level reviews within 30 working days

of receiving the request.

UM 7.2.4 written notification to the member within five working days of completing the review of the disposition of the appeal and of the potential right to appeal to an independent review organization.

UM 7.2.5 The managed care organization establishes procedures for registering and responding to expedited second-level appeals.

UM 7.2.5.1 An expedited appeal may be initiated by the member or by a practitioner acting on behalf of the member.

UM 7.2.5.2 The managed care organization makes the expedited appeal decision and notifies the member and practitioner(s) as expeditiously as the medical condition requires, but no later than three calendar days after the request is made.

UM 7.2.5.3 The managed care organization provides written confirmation of its decisions within two working days of providing notification of that decision, if the initial decision was not in writing.

UM 7.3 A procedure for allowing a practitioner or member representative to act on behalf of the member at any level of appeal.

UM 7.4 In at least one level of internal appeal, at least one of the people appointed to review an appeal involving clinical issues is an actively practicing practitioner in the same or a similar specialty who typically treats the medical condition, performs the procedure or provides the treatment. This individual did not participate in any of the managed care organization's prior decisions on the case.

UM 7.5 A procedure for providing independent, external review of final determinations including:

UM 7.5.1 eligibility criteria stating that the managed care organization offers members the right to an independent, third party, binding review whenever:

UM 7.5.1.1 the member is appealing an adverse determination that is based on medical necessity, as defined by NCQA;

UM 7.5.1.2 the managed care organization has completed two levels of internal reviews and

its decision is unfavorable to the member, or has elected to bypass one or both levels of internal review and proceed to the independent review or has exceeded its time limit for internal reviews, without good cause and without reaching a decision and

UM 7.5.1.3 the member has not withdrawn the appeal request, agreed to another dispute resolution proceeding or submitted to an external dispute resolution proceeding required by law.

UM 7.5.2 Notification to members about the independent appeals program as follows:

UM 7.5.2.1 general communications to members announce the availability of the right to independent review.

UM 7.5.2.2 letters informing members and practitioners of the upholding of a denial covered by this standard include notice of independent appeal rights and processes, contact information for the independent review organization and a statement that the member does not bear any costs of the independent review organization.

UM 7.5.2.3 letters inform members of the time and procedure for claim payment or approval of service in the event the independent review organization overturns the managed care organization's decision.

UM 7.5.3 Conduct of the appeal program as follows:

UM 7.5.3.1 The managed care organization contracts with an independent review organization that:

UM 7.5.3.1.1 conducts a thorough review in which it considers anew all previously determined facts, allows the introduction of new information, considers and assesses sound medical evidence, and makes a decision that is not bound by the decisions or conclusions of the

internal appeal.

UM 7.5.3.1.2 has no material professional, familial or financial conflicts of interest with the managed care organization.

UM 7.5.3.2 With the exception of exercising its rights as party to the appeal, the managed care organization must not attempt to interfere with the independent review organization's proceeding or appeal decision.

UM 7.5.3.3 The member is not required to bear costs of the independent review organization, including any filing fees.

UM 7.5.3.4 The member or his or her legal guardian may designate in writing a representative to act on his or her behalf.

UM 7.5.3.5 The managed care organization implements the independent review organization decision within the time frame specified by the independent review organization.

UM 7.5.3.6 The managed care organization obtains from the independent review organization, or maintains, data on each appeal case, including descriptions of the denied item(s), reasons for denial, independent review organization decisions and reasons for decisions. The managed care organization uses this information in evaluating its medical necessity decision-making process.

UM 8 Appropriate Handling of Appeals

The managed care organization adjudicates members' appeals in a thorough, appropriate and timely manner. The MCO meets all the requirements of standard UM 7 and its own standards for handling:

UM 8.1 first- and second-level appeals

UM 8.2 independent, external appeals.

UM 9 Evaluation of New Technology

The managed care organization evaluates the inclusion of new technologies and the new application of existing technologies in the benefit package. This includes medical and behavioral procedures, pharmaceuticals and devices.

UM 9.1 The managed care organization has a written description of the process used to determine whether new technologies and new uses of existing technologies are included in the benefit package.

UM 9.1.1 The written description includes the decision variables that the managed care organization uses to decide whether new technologies and the new application of existing technologies are included in the benefit package.

UM 9.1.2 The process includes a review of information from appropriate government regulatory bodies as well as published scientific evidence.

UM 9.1.3 Appropriate professionals participate in the process to decide whether to include new technologies and new uses of existing technologies in the benefit package.

UM 9.2 The managed care organization implements this process to assess new technologies and new applications of existing technologies.

UM 10 Satisfaction with the UM Process

The managed care organization evaluates member and practitioner satisfaction with the UM process.

UM 10.1 At least annually, the managed care organization gathers information from members and practitioners regarding their satisfaction with the UM process.

UM 10.2 The managed care organization addresses identified sources of dissatisfaction.

UM 11 Emergency Services

The managed care organization provides, arranges for or otherwise facilitates all needed emergency services, including appropriate coverage of costs.

UM 11.1 The managed care organization covers emergency services necessary to screen and stabilize members without precertification in cases where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.

UM 11.2 The managed care organization covers emergency services if an authorized representative acting for the managed care organization has authorized the provision of emergency services.

UM 12 Procedures for Pharmaceutical Management

The managed care organization ensures that its procedures for pharmaceutical management, if any, promote the clinically appropriate use of pharmaceuticals.

UM 12.1 The managed care organization's pharmaceutical management

procedures are based on sound clinical evidence, and the organization specifies how to apply the procedures in an appropriate manner based on the needs of individual patients.

UM 12.1.1 The pharmaceutical management procedures are clearly documented and there is a process for applying the procedures.

UM 12.1.2 The managed care organization reviews the pharmaceutical management procedures at least annually and updates the procedures as necessary.

UM 12.1.3 The managed care organization involves appropriate, actively practicing practitioners, including pharmacists, in the development and periodic updating of its pharmaceutical management procedures.

UM 12.1.4 The managed care organization provides practitioners its pharmaceutical management procedures and any changes the managed care organization makes to the procedures.

UM 12.2 Where the managed care organization restricts pharmacy benefits to a closed formulary, it has a process to consider medical necessity exceptions for members to obtain coverage of a pharmaceutical not on the formulary.

UM 13 Ensuring Appropriate Utilization

The managed care organization facilitates the delivery of appropriate care and monitors the impact of its UM program to detect and correct potential under- and overutilization of services.

UM 13.1 The managed care organization monitors relevant utilization data for each product line and for behavioral health services by product line to detect potential under- and overutilization.

UM 13.2 The managed care organization routinely analyzes all data collected to detect under- and overutilization.

UM 13.3 The managed care organization implements appropriate interventions whenever it identifies under- or overutilization.

UM 13.4 The managed care organization measures whether the interventions have been effective and implements strategies to achieve appropriate utilization.

UM 13.5 The managed care organization distributes to all its practitioners, providers, members and employees a statement describing its policy on financial incentives and requires practitioners, providers and staff who make utilization-related decisions and those who supervise them to sign a document acknowledging that they have received the

statement. This statement affirms that:

UM 13.5.1 UM decision making is based only on appropriateness of care-and service and existence of coverage.

UM 13.5.2 The managed care organization does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service care.

UM 13.5.3 Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

UM 14 Triage and Referral for Behavioral Health Care

(Applies Only to MCOs With a Centralized Triage and Referral Process for Behavioral Health, both delegated and nondelegated)

The managed care organization has written standards to ensure that any centralized triage and referral functions for behavioral health services are appropriately implemented, monitored and professionally managed.

UM 14.1 The managed care organization makes triage and referral decisions according to protocols that define the level of urgency and appropriate setting of care.

UM 14.2 The managed care organization adopts triage and referral protocols that are based on sound clinical evidence and currently accepted practices within the industry.

UM 14.2.1 The managed care organization uses protocols to specifically address mental health and substance abuse triage and referral.

UM 14.2.2 The managed care organization provides up-to-date protocols and guidelines to its triage and referral staff.

UM 14.3 The managed care organization ensures that triage and referral decisions not requiring clinical judgment are made by staff who have relevant knowledge, skills, and professional experience.

UM 14.4 The managed care organization ensures that triage and referral decisions requiring clinical judgment are made by a licensed behavioral health care practitioner with appropriate qualified experience.

UM 14.5 The managed care organization ensures that triage and referral staff are supervised by a licensed behavioral health care practitioner with a minimum of a master's degree and five years of post-master's clinical experience.

UM 14.6 The managed care organization ensures that a licensed psychiatrist or an appropriately licensed doctoral-level clinical psychologist experienced in-clinical risk management oversees triage and referral decisions.

UM 15 Delegation of UM

If the managed care organization delegates any UM activities, there is evidence of oversight of the delegated activity.

UM 15.1 A mutually agreed upon document describes:

- UM 15.1.1 the responsibilities of the managed care organization and the delegated entity;
- UM 15.1.2 the delegated activities;
- UM 15.1.3 the frequency of reporting to the managed care organization;
- UM 15.1.4 the process by which the managed care organization evaluates the delegated entity's performance and
- UM 15.1.5 the remedies, including revocation of the delegation, available to the managed care organization if the delegated entity does not fulfill its obligations.

UM 15.2 There is evidence that the managed care organization:

- UM 15.2.1 evaluates the delegated entity's capacity to perform the delegated activities prior to delegation;
- UM 15.2.2 approves the delegated entity's UM program annually;
- UM 15.2.3 evaluates regular reports as specified in UM 15.1.3 and
- UM 15.2.4 evaluates annually whether the delegated entity's activities are being conducted in accordance with the managed care organization's expectations and NCQA standards.

52.101: Appendix B: Standards for Quality Management and Improvement in the NCQA Surveyor Guidelines for the Accreditation of MCOs effective July 1, 2001

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QI 1 Program Structure

The managed care organization's quality improvement (QI) structures and processes are clearly defined and responsibility is assigned to appropriate individuals.

QI 1.1 A written description of the QI program outlines the program structure and content.

QI 1.1.1 The written description of the QI program specifically addresses the behavioral health care aspects of the program.

QI 1.1.2 The description of the program includes a section that addresses improving patient safety.

QI 1.2 The QI program is accountable to the governing body.

QI 1.3 The program description is evaluated annually and updated as necessary.

QI 1.4 A designated physician has substantial involvement in the implementation of the QI program.

QI 1.4.1 A designated behavioral health care practitioner is involved in the implementation of the behavioral health care aspects of the QI program.

QI 1.5 A committee oversees and is involved in QI activities.

QI 1.6 The program description specifies the role, structure and function, including frequency of meetings of the QI committee and other relevant committees.

QI 1.7 The annual QI work plan, or schedule of activities, includes the following:

QI 1.7.1 objectives, scope and planned projects or activities that address the quality and safety of clinical care and the quality of service for the year;

QI 1.7.2 planned monitoring of previously identified issues, including tracking of issues over time and

QI 1.7.3 planned evaluation of the QI program as described in QI 12.1.

QI 1.8 The QI program resources (e.g., personnel, analytic capabilities, data resources) are adequate to meet its needs.

QI 2 Program Operations

The managed care organization's quality improvement program is fully operational.

QI 2.1 The QI committee recommends policy decisions, reviews and evaluates the results of quality improvement activities, institutes needed actions, and ensures follow-up, as appropriate.

QI 2.2 There are contemporaneous minutes (i.e., created at the time the activity is conducted), dated and signed, that reflect all QI committee decisions and actions.

QI 2.3 The managed care organization's practitioners participate actively in the QI program.

QI 2.4 Upon request, the managed care organization makes available to its members and practitioners information about its QI program, including a description of the QI program and a report on the managed care organization's progress in meeting its goals.

QI 3 Health Services Contracting

Contracts with individual practitioners and organizational providers, including those making UM decisions, specify that contractors cooperate with the managed care organization's quality improvement program.

QI 3.1 Contracts with practitioners specifically require that:

QI 3.1.1 the practitioners cooperate with QI activities;

QI 3.1.2 the managed care organization has access to the practitioners' medical records to the extent permitted by state and federal law and

QI 3.1.3 the managed care organization allows open practitioner-patient communication regarding appropriate treatment alternatives and without penalizing practitioners for discussing medically necessary or appropriate care for the patient.

QI 3.2 Contracts with providers specifically require that:

QI 3.2.1 the providers cooperate with QI activities and

QI 3.2.2 the managed care organization has access to the providers' medical records to the extent permitted by state and federal law.

Note: "Practitioner" refers to an individual who provides care "provider" refers to an organization such as hospital, residential treatment center or rehabilitation facility.

QI 4 Availability of Practitioners

The managed care organization ensures that its network is sufficient in numbers and types of practitioners.

QI 4.1 In creating and maintaining its delivery system of practitioners, the managed care organization takes into consideration assessed special and cultural needs and preferences.

QI 4.2 The managed care organization implements mechanisms designed to ensure the availability of primary care practitioners.

QI 4.2.1 The managed care organization defines the practitioners who serve as primary care practitioners within its delivery system.

QI 4.2.2 The managed care organization establishes standards for the number and geographic distribution of primary care practitioners.

QI 4.2.4 The managed care organization identifies opportunities for improvement and decides which opportunities to pursue.

QI 4.2.5 The managed care organization implements interventions to improve its performance.

QI 4.2.6 The managed care organization measures the effectiveness of the interventions.

QI 4.3 The managed care organization implements mechanisms designed to ensure the availability of specialty care practitioners.

QI 4.3.1 The managed care organization establishes standards for the number and geographic distribution of specialty practitioners.

QI 4.3.2 The managed care organization collects and analyzes data to measure its performance against the standards established in QI 4.3.1.

QI 4.3.3 The managed care organization identifies opportunities for improvement and decides which opportunities to pursue.

QI 4.3.4 The managed care organization implements interventions to improve its performance.

QI 4.3.5 The managed care organization measures the effectiveness of the interventions.

QI 5 Accessibility of Services

The managed care organization establishes mechanisms to assure the accessibility of primary care services, behavioral health services and member services.

QI 5.1 The managed care organization establishes standards for access to

medical care:

QI 5.1.1 preventive care appointments;

QI 5.1.2 routine primary care appointments;

QI 5.1.3 urgent care appointments;

QI 5.1.4 emergency care and

QI 5.1.5 after-hours care.

QI 5.2 The managed care organization establishes standards for key elements of telephone customer service.

QI 5.3 The hours of operation and service availability for behavioral health care reflect the needs of members needing behavioral health care, as follows:

QI 5.3.1 A member with life-threatening emergency needs is seen immediately.

QI 5.3.2 A member with non-life-threatening emergency needs has access to care within 6 hours.

QI 5.3.3 A member with urgent needs has access to care within 48 hours.

QI 5.3.4 A member has access to a routine office visit within 10 working days.

QI 5.3.5 A member has telephone access to screening and triage, if applicable, as follows:

QI 5.3.5.1 callers reach a nonrecorded voice within 30 seconds and

QI 5.3.5.2 abandonment rates do not exceed 5 percent at any given time.

QI 5.4 The managed care organization collects and analyzes data to measure its performance against the standards.

QI 5.5 The managed care organization identifies opportunities for improvement and decides which opportunities to pursue.

QI 5.6 The managed care organization implements interventions to improve its performance.

QI 5.7 The managed care organization measures the effectiveness of the interventions.

QI 6 Member Satisfaction

The managed care organization implements mechanisms to assure member satisfaction.

QI 6.1 The managed care organization assesses member satisfaction by:

QI 6.1.1 evaluating member complaints and appeals and

QI 6.1.2 evaluating requests to change practitioners and/or sites.

QI 6.2 The managed care organization uses appropriate methods to collect data for the activities listed in QI 6.1.

QI 6.2.1 The appropriate population is identified.

QI 6.2.2 If sampling is used, appropriate samples are drawn from the affected population.

QI 6.2.3 Valid and reliable data are collected.

QI 6.3 The managed care organization analyzes data from at least the activities listed in QI 6.1 and the CAHPS® 2.0H survey.

QI 6.4 The managed care organization identifies opportunities for improvement and decides which opportunities to pursue.

QI 6.5 The managed care organization implements interventions to improve its performance.

QI 6.6 The managed care organization measures the effectiveness of the interventions.

QI 6.7 The managed care organization informs practitioners and providers of the results of member satisfaction activities.

QI 7 Health Management Systems

The managed care organization actively works to improve the health status of its members with chronic conditions.

QI 7.1 The managed care organization identifies members with chronic conditions and offers appropriate services and programs to assist in managing their conditions.

QI 7.2 The managed care organization informs and educates practitioners about using the health management programs for the members assigned to them.

QI 8 Clinical Practice Guidelines

The managed care organization is accountable for adopting and disseminating practice guidelines for the provision of acute, chronic and behavioral health services that are relevant to its enrolled membership.

QI 8.1 The clinical practice guidelines are based on reasonable medical evidence.

QI 8.2 The managed care organization involves its practitioners in the adoption of clinical practice guidelines.

QI 8.3 The managed care organization has developed a mechanism for reviewing the guidelines at least every two years and updating them as appropriate.

QI 8.4 The managed care organization distributes the guidelines to its practitioners.

QI 8.5 Annually, the managed care organization measures performance against at least three guidelines, one of which relates to behavioral health.

QI 8.6 Decision making in utilization management, member education, interpretation of covered benefits and other areas to which the clinical guidelines are applicable is consistent with the guidelines.

Note: These guidelines are in addition to the preventive care guidelines required in PH 1.

QI 9 Continuity and Coordination of Care

The managed care organization monitors the continuity and coordination of care that members receive.

QI 9.1 The managed care organization monitors the continuity and coordination of care that members receive across practices and provider sites, including at a minimum primary care practice sites with 50 or more members.

QI 9.2 The managed care organization monitors continuity and coordination of general medical care with behavioral health care. To this end, the organization collaborates with its behavioral health specialists to:

- QI 9.2.1 Exchange information in an effective, timely and confidential manner, including patient-approved communications between medical practitioners and behavioral health practitioners and providers.
- QI 9.2.2 Assess the appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care.
- QI 9.2.3 Evaluate the use of psychopharmacological medication, to increase appropriate use, decrease inappropriate use and reduce the incidence of adverse drug reactions.
- QI 9.2.4 Coordinate timely access for appropriate treatment and follow-up for individuals with coexisting medical and behavioral disorders.
- QI 9.2.5 Implement one preventive behavioral health guideline or program.

QI 9.3 The managed care organization collects and analyzes data to evaluate

continuity and coordination of care.

QI 9.3.1 The managed care organization analyzes data to identify any opportunities for improvement.

QI 9.3.2 The managed care organization collaborates with its behavioral health specialists to identify an opportunity to improve coordination of behavioral health with general medical care.

QI 9.4 The managed care organization implements interventions to improve continuity and coordination of care.

QI 9.4.1 The managed care organization implements interventions when it identifies an opportunity for improvement.

QI 9.4.2 The managed care organization collaborates with its behavioral health specialists to take action to improve coordination of behavioral health with general medical care.

QI 9.5 To ensure continuity and coordination of care, the managed care organization notifies members affected by the termination of a practitioner or practice site and assists them in selecting a new practitioner or site.

QI 9.5.1 The managed care organization notifies members affected by the termination of a primary care practitioner or practice site at least 30 calendar days prior to the effective termination date and assists them in selecting a different primary care practitioner or site.

QI 9.5.2 The managed care organization notifies members being seen regularly by a specialist or specialty group whose contract is terminated at least 30 calendar days prior to the effective termination date and assists them in selecting a different practitioner or practice.

QI 9.6 When a practitioner's contract is discontinued, given certain conditions, the managed care organization allows members to have continued access to that practitioner under the following circumstances:

QI 9.6.1 Members undergoing active treatment for a chronic or acute medical condition have access to their discontinued practitioner through the current period of active treatment or for up to 90 calendar days, whichever is shorter.

QI 9.6.2 Members in their second or third trimester of pregnancy have access to their discontinued practitioner through the postpartum period.

QI 10 Clinical Measurement Activities

The managed care organization uses data collection, measurement and analysis to track clinical issues that are relevant to its population.

QI 10.1 At a minimum, the managed care organization adopts or establishes quantitative measures to assess performance and to identify and prioritize areas for improvement for three clinical issues, including at least one behavioral health issue.

QI 10.1.1 The measures used to assess performance are objective and quantifiable.

QI 10.1.2 The measures are based on current scientific knowledge and clinical experience.

QI 10.1.3 Each measure has an established goal and/or a benchmark.

QI 10.2 The managed care organization uses appropriate methods to collect data for each assessment measure.

QI 10.2.1 The affected population is identified.

QI 10.2.2 If sampling is used, appropriate samples are drawn from the affected population.

QI 10.2.3 Valid and reliable data are collected.

QI 10.3 The managed care organization analyzes data collected for each assessment measure.

QI 10.3.1 There is a quantitative analysis of the assessment data.

QI 10.3.2 Appropriate personnel, including practitioners, evaluate the analyzed data to identify barriers to improvement that are related to the clinical practice and/or administrative aspects of the delivery system.

Note: These measurement activities are in addition to the measurement activities required in QI 4, QI 5 and QI 6.

QI 11 Intervention and Follow-Up for Clinical Issues

The managed care organization takes action to improve quality by addressing the opportunities for improving performance identified in QI 10. The managed care organization also assesses the effectiveness of these interventions through systematic follow-up.

QI 11.1 The managed care organization follows up the opportunities for improvement identified through assessment and evaluation activities.

QI 11.1.1 The managed care organization identifies opportunities for improvement and decides which opportunities to pursue.

QI 11.1.2 The managed care organization implements interventions to

improve practitioner and system performance, as appropriate.

QI 11.1.3 The managed care organization measures whether the interventions have been effective.

QI 12 Effectiveness of the QI Program

The managed care organization evaluates the overall effectiveness of its QI program in addressing the quality and safety of clinical care and the quality of service and demonstrates improvements in the quality of clinical care and the quality of service to its members.

QI 12.1 There is an annual written evaluation of the QI program. This evaluation includes:

QI 12.1.1 a description of completed and ongoing QI activities that address the quality and safety of clinical care and the quality of service;

QI 12.1.2 trending of measures to assess performance in the quality and-safety of clinical care and the quality of service;

QI 12.1.3 an analysis of whether there have been demonstrated improvements in the quality of clinical care and the quality of service to members and

QI 12.1.4 an evaluation of the overall effectiveness of the QI program, including progress toward influencing safe clinical practices throughout the network.

QI 12.2 There is evidence that QI activities have contributed to meaningful improvement in the quality of clinical care and quality of service provided to members.

QI 13 Delegation of QI Activity

If the managed care organization delegates any QI activities, there is evidence of oversight of the delegated activity.

QI 13.1 A mutually agreed upon document describes:

QI 13.1.1 the responsibilities of the managed care organization and the delegated entity;

QI 13.1.2 the delegated activities;

QI 13.1.3 the frequency of reporting to the managed care organization;

QI 13.1.4 the process by which the managed care organization evaluates the delegated entity's performance and

QI 13.1.5 the remedies, including revocation of the delegation,

available to the managed care organization if the delegated entity does not fulfill its obligations.

QI 13.2 There is evidence that the managed care organization:

- QI 13.2.1 evaluates the delegated entity's capacity to perform the delegated activities prior to delegation;
- QI 13.2.2 approves the delegated entity's QI work plan and QI program description annually;
- QI 13.2.3 evaluates regular reports as specified in QI 13.1.3 and
- QI 13.2.4 evaluates annually whether the delegated entity's activities are being conducted in accordance with the managed care organization's expectations and NCQA standards.

52.102: Appendix C: Standards for Credentialing and Recredentialing in the NCQA Surveyor Guidelines for the Accreditation of MCOs effective July 1, 2001

This Appendix includes material of which the NCQA is the copyright owner. Such material appears herein under license from the NCQA.

CR 1 Credentialing Policies

The managed care organization documents the mechanism for the credentialing and recredentialing of licensed independent practitioners with whom it contracts or employs and who fall within its scope of authority and action. At a minimum, the policies and procedures define:

CR 1.1 the scope of practitioners covered;

CR 1.2 the criteria and the primary source verification of information used to meet these criteria;

CR 1.3 the process used to make decisions;

CR 1.4 the process to delegate credentialing or recredentialing;

CR 1.5 the right of practitioners to review the information submitted in support of their credentialing applications;

CR 1.6 the process for notification to a practitioner of any information obtained during the managed care organization's credentialing process that varies substantially from the information provided to the managed care organization by the practitioner;

CR 1.7 the practitioner's right to correct erroneous information;

CR 1.8 the medical director's or other designated physician's direct responsibility and participation in the credentialing program and

CR 1.9 the process used to ensure the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.

CR 2 Credentialing Committee

The managed care organization designates a credentialing committee that makes recommendations regarding credentialing decisions using a peer review process.

CR 3 Initial Primary Source Verification

At the time of credentialing, the managed care organization verifies at least the following information from primary sources (unless otherwise indicated):

CR 3.1 a current valid license to practice;

CR 3.2 a valid DEA or CDS certificate, as applicable;

Note: DEA or CDS certificates are not applicable for chiropractors. CDS certificates are not applicable for dentists; however, DEA certificates may be applicable.

CR 3.3 education and training of practitioners;

CR 3.4 board certification if the practitioner states that he/she is board certified on the application;

Note: Verification of board certification is not applicable for chiropractors.

CR 3.5 work history;

Note: Primary source verification is not required for work history.

CR 3.6 history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner.

CR 4 Application and Attestation

The applicant completes an application for membership. The application includes a current and signed attestation by the applicant regarding:

CR 4.1 reasons for any inability to perform the essential functions of the position, with or without accommodation;[*]

CR 4.2 lack of present illegal drug use;[*]

CR 4.3 history of loss of license and felony convictions;

CR 4.4 history of loss or limitation of privileges or disciplinary activity;

CR 4.5 current malpractice insurance coverage and

CR 4.6 the correctness and completeness of the application.

CR 5 Initial Sanction Information

There is documentation that before making a credentialing decision, the managed care organization has received the following information and includes this information in the credentialing files.

CR 5.1 The managed care organization has received information from the National Practitioner Data Bank (NPDB) and includes it in the credentialing files.

Note: NPDB query is not required for chiropractors and podiatrists.

CR 5.2 The managed care organization has received information about

[*] The exact statement or inquiry may vary depending on applicable legal requirements such as the Americans with Disabilities Act (ADA).

sanctions or limitations on licensure as applicable and includes it in the credentialing files.

CR 5.3 The managed care organization has reviewed for previous sanction activity by Medicare and Medicaid and includes it in the credentialing files.

Note: Medicare/Medicaid query is not applicable for dentists.

CR 6 Initial Credentialing Site Visits

The managed care organization has a process for ensuring that the offices of all primary care practitioners, obstetricians/gynecologists (OB/GYNs) and high-volume behavioral health care practitioners meet the managed care organization's office site standards.

CR 6.1 The managed care organization sets standards for office sites and establishes thresholds for acceptable performance against the standards.

CR 6.2 The managed care organization conducts an initial site visit that evaluates the site against the managed care organization's standards.

CR 6.3 The managed care organization conducts an initial evaluation of the medical/treatment record keeping practices at each site to ensure conformity with the managed care organization's standards.

CR 6.4 The managed care organization institutes actions for improvement with sites that do not meet the thresholds.

CR 6.5 The managed care organization evaluates the effectiveness of the actions at least every six months until sites with deficiencies meet the thresholds.

CR 6.6 The managed care organization follows the same procedures as for an initial site visit when a primary care practitioner, OB/GYN or high-volume behavioral health practitioner relocates or opens a new site.

CR 6.7 The managed care organization has procedures for detecting deficiencies subsequent to the initial site visit. When the managed care organization identifies new deficiencies, it reevaluates the site and institutes actions for improvement.

CR 7 Recredentialing Primary Source Verification

The managed care organization formally recredentials its practitioners at least every three years. During the recredentialing process it verifies at least the following information from primary sources (unless otherwise indicated):

CR 7.1 a valid state license to practice;

CR 7.2 a valid DEA or CDS certificate, as applicable;

Note: DEA or CDS certificates are not applicable for chiropractors. CDS certificates are not applicable for dentists.

CR 7.3 board certification, if the practitioner states that he/she is board certified;

Note: MCOs must verify board certification at recredentialing only if the practitioner's board certification has expired or is new since the practitioner's last credentialing. Board certification is not applicable for chiropractors.

CR 7.4 history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner and

CR 7.5 a current, signed attestation by the applicant regarding:

CR 7.5.1 reasons for any inability to perform the essential functions of the position, with or without accommodation;*

CR 7.5.2 lack of present illegal drug use;*

CR 7.5.3 history of loss or limitation of privileges or disciplinary activity;

CR 7.5.4 current malpractice insurance coverage and

CR 7.5.5 the correctness and completeness of the application.

CR 8 Recredentialing Sanction Information

There is documentation that, before making a recredentialing decision, the managed care organization has received the following information on the practitioner and includes this information in the recredentialing files.

CR 8.1 The managed care organization has received information from the National Practitioner Data Bank and includes it in the recredentialing files.

Note: NPDB query is not required for chiropractors and podiatrists.

CR 8.2 The managed care organization has received information about sanctions or limitations on licensure, as applicable, and includes it in the recredentialing files.

CR 8.3 The managed care organization has reviewed for previous sanction activity by Medicare and Medicaid and records this in the recredentialing files.

Note: Medicare/Medicaid query is not applicable for dentists.

* The exact statement or inquiry may vary depending on applicable legal requirements such as the Americans with Disabilities Act (ADA).

CR 9 Performance Monitoring

The managed care organization incorporates information from quality improvement activities in its recredentialing decision-making process for primary care practitioners and high-volume behavioral health care practitioners.

CR 9.1 member complaints

CR 9.2 information from quality improvement activities

CR 10 Ongoing Monitoring of Sanctions and Complaints

The managed care organization has implemented policies and procedures for the ongoing monitoring of practitioner sanctions and complaints between recredentialing cycles. The organization has taken appropriate action against practitioners when it identifies occurrences of poor quality.

CR 10.1 The managed care organization has a written policy and procedure that addresses the ongoing monitoring and use of the following types of information:

CR 10.1.1 Medicare and Medicaid sanctions;

CR 10.1.2 sanctions or limitations on licensure and

CR 10.1.3 complaints.

CR 10.2 The managed care organization implements the policy and procedure by regularly obtaining and reviewing documentation on sanctions and complaints.

CR 10.3 The managed care organization implements appropriate interventions when it identifies occurrences of poor quality.

CR 11 Notification to Authorities and Practitioner Appeal Rights

When a managed care organization has taken actions against a practitioner for quality reasons, the organization offers a formal appeal process and reports the action to the appropriate authorities.

CR 11.1 The managed care organization has procedures for, and documentation of implementation, as appropriate, reporting of serious quality deficiencies that could result in a practitioner's suspension or termination to appropriate authorities.

CR 11.2 The managed care organization has an appeal process for instances in which the managed care organization chooses to alter the conditions of the practitioner's participation based on issues of quality of care and/or service. The managed care organization informs practitioners of the appeal process.

CR 12 Assessment of Organizational Providers

The managed care organization has written policies and procedures for the initial and ongoing assessment of organizational providers with which it intends to contract.

CR 12.1 The managed care organization includes at least the following medical and behavioral health care providers:

CR 12.1.1 hospitals, home health agencies, skilled nursing facilities, nursing homes, and free standing surgical centers;

CR 12.1.2 behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting.

CR 12.2 The managed care organization confirms that the provider is in good standing with state and federal regulatory bodies and

CR 12.3 The managed care organization confirms that the provider has been reviewed and approved by an accrediting body or

CR 12.4 If the provider has not been approved by an accrediting body, the managed care organization develops and implements standards of participation.

CR 12.5 At least every three years, the managed care organization confirms that the provider continues to be in good standing with the state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body.

CR 13 Delegation of Credentialing

If the managed care organization delegates any credentialing and recredentialing activities, there is documentation of oversight of the delegated activity.

CR 13.1 A mutually agreed upon document describes:

CR 13.1.1 the responsibilities of the managed care organization and the delegated entity;

CR 13.1.2 the delegated activities;

CR 13.1.3 the process by which the managed care organization evaluates the delegated entity's performance and

CR 13.1.4 the remedies, including revocation of the delegation, available to the managed care organization if the delegated entity does not fulfill its obligations.

CR 13.2 The managed care organization retains the right, based on quality issues, to approve new practitioners, providers and sites and to terminate or suspend individual practitioners or providers.

CR 13.3 There is documentation that the managed care organization:

CR 13.3.1 evaluates the delegated entity's capacity to perform the delegated activities prior to delegation and

CR 13.3.2 evaluates annually whether the delegated entity's activities are being conducted in accordance with the managed care organization's expectations and NCQA standards.

52.103: Appendix D: Standards for Preventive Health Services in the NCQA Surveyor Guidelines for the Accreditation of MCOs effective July 1, 2001

This Appendix includes material of which the NCQA is the copyright owner. Such material appears herein under license from the NCQA.

PH 1 Adoption of Preventive Health Guidelines

The managed care organization has preventive health guidelines for prevention or early detection of illness and disease.

PH 1.1 The managed care organization has guidelines for the following categories:
Prenatal and perinatal care
Preventive care for infants up to 24 months;
Preventive care for children and adolescents, 2–19 years
Preventive care for adults, 20–64 years
Preventive care for the elderly, 65 years and older

PH 1.2 Each guideline describes the prevention or early detection interventions and the recommended frequency and conditions under which the interventions are required. The managed care organization documents the scientific basis or authority that it based the preventive health guidelines.

PH 1.3 Practitioners from the managed care organization who have appropriate knowledge have been involved in the adoption of the preventive health guidelines.

PH 1.4 These preventive health guidelines or its predecessors have been available for use for at least two years.

PH 1.5 For those preventive health guidelines that have been in place for at least two years, there is evidence of review and update at least once every two years, where appropriate.

PH 2 Distribution of Guidelines to Practitioners

The managed care organization distributes the preventive health guidelines and any updates to its practitioners.

PH 3 Health Promotion with Members

The managed care organization regularly encourages its members to use preventive health services.

PH 3.1 The managed care organization distributes preventive health guidelines to members annually.

PH 3.2 The managed care organization informs and encourages members to use the health promotion, health education and preventive health

services available.

PH 3.3 The managed care organization identifies specific members who, according to demographic and other identifiable health factors, may be at risk for specific health problems and urges these members to use appropriate health promotion and prevention services.

PH 4 Delegation of PH

If the managed care organization delegates any preventive health activities, there is evidence of oversight of the delegated activity.

PH 4.1 A mutually agreed upon document describes:

- PH 4.1.1 the responsibilities of the managed care organization and the delegated entity;
- PH 4.1.2 the delegated activities;
- PH 4.1.3 the frequency of reporting to the managed care organization;
- PH 4.1.4 the process by which the managed care organization evaluates the delegated entity's performance and
- PH 4.1.5 the remedies, including revocation of the delegation, available to the managed care organization if the delegated entity does not fulfill its obligations.

PH 4.2 There is evidence that the managed care organization:

- PH 4.2.1 evaluates the delegated entity's capacity to perform the delegated activities prior to delegation;
- PH 4.2.2 approves the delegated entity's preventive health work plan annually;
- PH 4.2.3 evaluates regular reports as specified in PH 4.1.3 and
- PH 4.2.4 evaluates annually whether the delegated entity's activities are being conducted in accordance with the managed care organization's expectations and NCQA standards.

52.104: Appendix E: Standards and Points in Appendix 1 in the NCQA Surveyor Guidelines for the Accreditation of MCOs effective July 1, 2001

This Appendix includes material of which the NCQA is the copyright owner. Such material appears herein under license from the NCQA.

A carrier shall not be accredited unless the carrier scores 65 percent or higher of the points described below for those requirements applicable to that carrier's health plans.

2001 Standard	Standard Description	2001 MCO Points
	Utilization Management	
UM 1	Utilization Management Structure	0.3
UM 2	Clinical Criteria for UM Decisions	2.0
UM 3	Appropriate Professionals	1.4
UM 4	Timeliness of UM Decisions	2.0
UM 5	Medical Information	1.2
UM 6	Denial Notices	1.5
UM 7	Appeal Policies and Procedures	1.0
UM 8	Appeal Handling	3.5
UM 9	Evaluation of New Technology	1.5
UM 10	Satisfaction with the UM Process	2.5
UM 11	Emergency Services	1.5
UM 12	Procedures for Pharmaceutical Management	1.0
UM 13	Ensuring Appropriate Service and Coverage	2.2
UM 14	Triage and Referral for Behavioral Health Care	0.4
UM 15	Delegation of UM	Varies
	Total Utilization Management	**22**
	Quality Management and Improvement	
QI 1	Program Structure	0.3
QI 2	Program Operations	0.3
QI 3	Health Services Contracting	0.5
QI 4	Availability of Practitioners	2.0
QI 5	Accessibility of Services	3.2
QI 6	Member Satisfaction	3.5
QI 7	Health Management Systems	3.0
QI 8	Clinical Practice Guidelines	3.0
QI 9	Continuity and Coordination of Care	2.2
QI 10	Clinical Measurement Activities	1.5
QI 11	Intervention and Follow-up for Clinical Issues	1.5

2001 Standard	Standard Description	2001 MCO Points
QI 12	Effectiveness of the QI Program	4.0
QI 13	Delegation of QI Activity	Varies
	Total Quality Management and Improvement	**25**
	Credentialing and Recredentialing	
CR 1	Credentialing Policies	0.1
CR 2	Credentialing Committee	0.2
CR 3	Initial Primary Source Verification	1.2
CR 4	Application and Attestation	0.4
CR 5	Initial Sanction Information	1.1
CR 6	Initial Credentialing Site Visits	1.4
CR 7	Recredentialing Primary Source Verification	1.1
CR 8	Recredentialing Sanction Information	1.1
CR 9	Performance Monitoring	1.1
CR 10	Ongoing Monitoring of Sanctions and Complaints	1.3
CR 11	Practitioner Appeal Rights	0.4
CR 12	Assessment of Organizational Providers	0.6
CR 13	Delegation of Credentialing	Varies
	Total Credentialing and Recredentialing	**10**
	Preventive Health	
PH 1	Adoption of Preventive Health Guidelines	1.5
PH 2	Distribution of Guidelines to Practitioners	1.0
PH 3	Health Promotion with Members	1.0
PH 4	Delegation of PH	Varies
	Total Preventive Health	**3.5**

52.110: Appendix F: Standards for Utilization Management in the NCQA Standards and Surveyor Guidelines for the Accreditation of PPO Plans effective July 31, 2000

This Appendix includes material of which the NCQA is the copyright owner. Such material appears herein under license from the NCQA.

UM 1 Utilization Management Structure

(Applies to all UM functions, whether delegated or not delegated.)

The organization's utilization management (UM) structures and processes are clearly defined and responsibility is assigned to appropriate individuals.

UM 1.1 A written description of the UM program outlines the program structure and accountability.

UM 1.1.1 The description of the program specifically addresses the behavioral health care aspects of the program.

UM 1.2 A designated senior physician has substantial involvement in UM program implementation.

UM 1.2.1 A designated behavioral health care practitioner has substantial involvement in the implementation of the behavioral health care aspects of the UM program.

UM 1.3 The description includes the scope of the program and the processes and information sources used to make determinations of benefit coverage and medical necessity.

UM 1.4 The UM program is evaluated and approved annually by senior management or the QI committee. It is updated as necessary.

UM 2 Clinical Criteria for UM Decisions

To make utilization decisions based on medical necessity, the organization uses written criteria based on sound clinical evidence and specifies procedures for applying those criteria in an appropriate manner.

UM 2.1 The criteria for determining medical necessity are clearly documented and include procedures for applying criteria based on the needs of individual patients and characteristics of the local delivery system.

UM 2.2 The organization involves appropriate, actively practicing practitioners in its development or adoption of criteria and in the development and review of procedures for applying the criteria.

UM 2.3 The organization reviews the criteria at specified intervals and updates them as necessary.

UM 2.4 The organization states in writing how practitioners can obtain the UM criteria and makes the criteria available to its practitioners upon

request.

UM 2.5 At least annually, the organization evaluates the consistency with which the health care professionals involved in utilization review apply the criteria in decision making.

UM 3 Appropriate Professionals

Qualified licensed health professionals assess the clinical information used to support UM decisions.

UM 3.1 Appropriately licensed health professionals supervise all the review decisions.

UM 3.2 An appropriate practitioner reviews any denial of care.

UM 3.2.1 A licensed physician reviews any denial that is based on medical necessity.

UM 3.2.2 A psychiatrist, doctoral-level clinical psychologist, or certified addiction medicine specialist reviews any denial of behavioral health care that is based on medical necessity.

UM 3.3 The organization has written procedures for using board-certified physicians from appropriate specialty areas to assist in making determinations of medical necessity.

UM 4 Timeliness of UM Decisions

The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation.

UM 4.1 The organization follows NCQA's standards for the timeliness of UM decision making.

UM 4.1.1 For precertifications of nonurgent care, the organization makes decisions within two working days of obtaining all the necessary information.

UM 4.1.2 For precertifications of nonurgent care, the organization notifies practitioners of the decisions within one working day of making the decision.

UM 4.1.3 For precertifications of nonurgent care that result in a denial, the organization gives enrollees and practitioners written or electronic confirmation of the decisions within two working days of making the decision.

UM 4.1.4 For precertifications of urgent care, the organization makes decisions and notifies practitioners of the decisions within one calendar day. If the decision is a denial, the PPO must also notify enrollees within one calendar day.

UM 4.1.5 For precertifications of urgent care that result in a denial,

the organization notifies both enrollees and practitioners how to initiate an expedited appeal at the time they are notified of the denial.

UM 4.1.6 For precertifications of urgent care that result in a denial, the organization gives enrollees and practitioners written or electronic confirmation of the decisions within two working days of making the decision.

UM 4.1.7 For concurrent review of services, the organization makes decisions for:

UM 4.1.7.1 inpatient, intensive outpatient and residential behavioral care within one working day of obtaining all the necessary information.

UM 4.1.7.2 ongoing ambulatory care within 10 working days of obtaining all the necessary information.

UM 4.1.8 For concurrent review, the organization notifies practitioners of decisions within one working day of making the decision.

UM 4.1.9 For concurrent review decisions that result in a denial, the organization gives enrollees and practitioners written or electronic confirmation within one working day of the original notification.

UM 4.1.10 For concurrent review decisions that result in a denial, the organization notifies both enrollees and practitioners how to initiate an expedited appeal at the time they are notified of the denial.

UM 4.1.11 For retrospective review, the organization makes the decision within 30 working days of obtaining all the necessary information.

UM 4.1.12 For retrospective review, the organization notifies practitioners and enrollees of denials in writing within five working days of making the decision.

UM 5 Clinical Information

When making a determination of coverage based on medical necessity, the organization obtains relevant clinical information and consults with the treating physician.

UM 5.1 A written description identifies the information that is collected to support UM decision making.

UM 5.2 There is documentation that relevant clinical information is gathered consistently to support UM decision making.

UM 5.3 The organization assists with an enrollee's transition to other care, if necessary, when benefits end.

UM 6 Denial Notices

The organization clearly documents and communicates the reasons for each denial.

UM 6.1 The organization makes available to practitioners a physician reviewer to discuss by telephone determinations based on medical necessity.

UM 6.2 The organization sends written notification to enrollees and practitioners, as appropriate, of the reason for each denial, including the specific utilization review criteria or benefits provisions used in the determination.

UM 6.3 The organization includes information about the appeal process in all denial notifications.

UM 7 Policies for Appeals

The organization has written policies and procedures for the thorough, appropriate and timely resolution of enrollee appeals.

UM 7.1 Procedures for registering and responding to oral and written first-level appeals include the following elements:

UM 7.1.1 notification to the enrollee of the appeal process within five working days of receiving a request for a first-level appeal;

UM 7.1.2 documentation of the substance of the appeal and the actions taken;

UM 7.1.3 full investigation of the substance of the appeal, including any aspects of clinical care involved;

UM 7.1.4 resolution of the appeal, including:

UM 7.1.4.1 The organization appoints a person or people to review the first-level appeal who were not involved in the initial determination.

UM 7.1.4.2 If the organization cannot make a decision within 30 working days due to circumstances beyond its control, the organization issues a written decision within 15 additional working days and provides notice to the enrollee with the reasons for the delay before the 30th working day.

UM 7.1.5 written notification to the enrollee of the disposition of the appeal and the right to appeal further.

UM 7.1.6 The organization establishes procedures for registering and responding to expedited first-level appeals.

UM 7.1.6.1 An expedited appeal may be initiated by the enrollee or by a practitioner acting on behalf of the enrollee.

UM 7.1.6.2 The organization makes the expedited appeal decision and notifies the enrollee and practitioner(s) as expeditiously as the medical condition requires, but no later than three calendar days after the request is made.

UM 7.1.6.3 The organization provides written confirmation of its decisions within two working days of providing notification of that decision, if the initial decision was not in writing.

UM 7.2 Procedures for registering and responding to oral and written second-level appeals include the following elements:

UM 7.2.1 documentation of the substance of the appeal and the actions taken;

UM 7.2.2 full investigation of the substance of the appeal, including any aspects of clinical care involved;

UM 7.2.3 resolution of the appeal, including:

UM 7.2.3.1 The organization appoints a panel for the second-level review composed of representatives not involved in any previous decisions regarding the appeal.

UM 7.2.3.2 The enrollee has a right to appear before the panel. An enrollee who cannot appear in person at the panel hearing is provided the opportunity to communicate with the panel by conference call or other appropriate technology and

UM 7.2.3.3 The organization resolves second-level reviews within 30 working days of receiving the request.

UM 7.2.4 written notification to the enrollee within five working days of completing the review of the disposition of the appeal and of the potential right to appeal to an independent review organization.

UM 7.2.5 The organization establishes procedures for registering and

responding to expedited second-level appeals.

UM 7.2.5.1 An expedited appeal may be initiated by the enrollee or by a practitioner acting on behalf of the enrollee.

UM 7.2.5.2 The organization makes the expedited appeal decision and notifies the enrollee and practitioner(s) as expeditiously as the medical condition requires, but no later than three calendar days after the request is made.

UM 7.2.5.3 The organization provides written confirmation of its decisions within two working days of providing notification of that decision, if the initial decision was not in writing.

UM 7.3 A procedure for allowing a practitioner or enrollee representative to act on behalf of the enrollee at any level of appeal.

UM 7.4 In at least one level of internal appeal, at least one of the people appointed to review an appeal involving clinical issues is an actively practicing practitioner in the same or a similar specialty who typically treats the medical condition, performs the procedure or provides the treatment. This individual did not participate in any of the organization's prior decisions on the case.

UM 7.5 A procedure for providing independent, external review of final determinations* including:

UM 7.5.1 eligibility criteria stating that the organization offers enrollees the right to an independent, third party, binding review whenever:

UM 7.5.1.1 the enrollee is appealing an adverse determination that is based on medical necessity, as defined by NCQA;

UM 7.5.1.2 the organization has completed two levels of internal reviews and its decision is unfavorable to the enrollee, or has elected to bypass one or both levels of internal review and proceed to the independent review or has exceeded its time limit for internal reviews, without good cause and without reaching a decision and

* Most of UM 7.5 is relevant only to MCOs in states that do not have laws providing for external review. In states with laws, NCQA surveys only the MCO's compliance with UM 7.5.2 – notification to members.

UM 7.5.1.3 the enrollee has not withdrawn the appeal request, agreed to another dispute resolution proceeding or submitted to an external dispute resolution proceeding required by law.

UM 7.5.2 Notification to enrollees about the independent appeals program as follows:

UM 7.5.2.1 general communications to enrollees announce the availability of the right to independent review.

UM 7.5.2.2 letters informing enrollees and practitioners of the upholding of a denial covered by this standard include notice of independent appeal rights and processes, contact information for the independent review organization and a statement that the enrollee does not bear any costs of the independent review organization.

UM 7.5.2.3 letters inform enrollees of the time and procedure for claim payment or approval of service in the event the independent review organization overturns the organization's decision.

UM 7.5.3 Conduct of the appeal program as follows:

UM 7.5.3.1 The organization contracts with an independent review organization that:

UM 7.5.3.1.1 conducts a thorough review in which it considers anew all previously determined facts, allows the introduction of new information, considers and assesses sound medical evidence, and makes a decision that is not bound by the decisions or conclusions of the internal appeal.

UM 7.5.3.1.2 has no material professional, familial or financial conflicts of interest with the organization.

UM 7.5.3.2 With the exception of exercising its rights as party to the appeal, the organization must not attempt to interfere with the

independent review organization's proceeding or appeal decision.

UM 7.5.3.3 The enrollee is not required to bear costs of the independent review organization, including any filing fees.

UM 7.5.3.4 The enrollee or his or her legal guardian may designate in writing a representative to act on his or her behalf.

UM 7.5.3.5 The organization implements the independent review organization decision within the time frame specified by the independent review organization.

UM 7.5.3.6 The organization obtains from the independent review organization, or maintains, data on each appeal case, including descriptions of the denied item(s), reasons for denial, independent review organization decisions and reasons for decisions. The organization uses this information in evaluating its medical necessity decision-making process.

UM 8 Appropriate Handling of Appeals

The organization adjudicates enrollees' appeals in a thorough, appropriate and timely manner. The PPO meets all the requirements of standard UM 7 and its own standards for handling:

UM 8.1 first- and second-level appeals

UM 8.2 independent, external appeals.

UM 9 Evaluation of New Technology

The organization evaluates the inclusion of new technologies and the new application of existing technologies in the benefit package. This includes medical and behavioral procedures, pharmaceuticals and devices.

UM 9.1 The organization has a written description of the process used to determine whether new technologies and new uses of existing technologies.

UM 9.1.1 The written description includes the decision variables that the organization uses to decide whether new technologies and the new application of existing technologies are included in the benefit package.

UM 9.1.2 The process includes a review of information from

appropriate government regulatory bodies as well as published scientific evidence.

UM 9.1.3 Appropriate professionals participate in the process to decide whether to include new technologies and new uses of existing technologies in the benefit package.

UM 9.2 The organization implements this process to assess new technologies and new applications of existing technologies.

UM 10 Satisfaction with the UM Process

The organization evaluates enrollee and practitioner satisfaction with the UM process.

UM 10.1 At least annually, the organization gathers information from enrollees and practitioners regarding their satisfaction with the UM process.

UM 10.2 The organization addresses identified sources of dissatisfaction.

UM 11 Emergency Services

The organization provides, arranges for or otherwise facilitates all needed emergency services, including appropriate coverage of costs.

UM 11.1 The organization covers emergency services necessary to screen and stabilize enrollees without precertification in cases where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.

UM 11.2 The organization covers emergency services if an authorized representative acting for the organization has authorized the provision of emergency services.

UM 12 Procedures for Pharmaceutical Management

The organization ensures that its procedures for pharmaceutical management, if any, promote the clinically appropriate use of pharmaceuticals.

UM 12.1 The organization's pharmaceutical management procedures are based on sound clinical evidence, and the organization specifies how to apply the procedures in an appropriate manner based on the needs of individual patients.

UM 12.1.1 The pharmaceutical management procedures are clearly documented and there is a process for applying the procedures.

UM 12.1.2 The organization reviews the pharmaceutical management procedures at least annually and updates the procedures as necessary.

UM 12.1.3 The organization involves appropriate, actively practicing

practitioners, including pharmacists, in the development and periodic updating of its pharmaceutical management procedures.

UM 12.1.4 The organization provides practitioners its pharmaceutical management procedures and any changes the organization makes to the procedures.

UM 12.2 Where the organization restricts pharmacy benefits to a closed formulary, it has a process to consider medical necessity exceptions for enrollees to obtain coverage of a pharmaceutical not on the formulary.

Standard UM 13

The standard is not included in PPO Plan Accreditation. The number is reserved to maintain consistency with NCQA's other accreditation programs.

UM 14 Triage and Referral for Behavioral Health Care

(Applies only to PPOs with a centralized triage and referral process for behavioral health, whether delegated or not delegated.)

The organization has written standards to ensure that any centralized triage and referral functions for behavioral health services are appropriately implemented, monitored and professionally managed.

UM 14.1 The organization makes triage and referral decisions according to protocols that define the level of urgency and appropriate setting of care.

UM 14.2 The organization adopts triage and referral protocols that are based on sound clinical evidence and currently accepted practices within the industry.

UM 14.2.1 The organization uses protocols to specifically address mental health and substance abuse triage and referral.

UM 14.2.2 The organization provides up-to-date protocols and guidelines to its triage and referral staff.

UM 14.3 The organization ensures that triage and referral decisions not requiring clinical judgment are made by staff who have relevant knowledge, skills, and professional experience.

UM 14.4 The organization ensures that triage and referral decisions requiring clinical judgment are made by a licensed behavioral health care practitioner with appropriate qualified experience.

UM 14.5 The organization ensures that triage and referral staff are supervised by a licensed behavioral health care practitioner with a minimum of a master's degree and five years of post-master's clinical experience.

UM 14.6 The organization ensures that a licensed psychiatrist or an appropriately licensed doctoral-level clinical psychologist experienced in-clinical risk management oversees triage and referral decisions.

UM 15 Delegation of UM

If the organization delegates any UM activities, there is evidence of oversight of the delegated activity.

UM 15.1 A mutually agreed upon document describes:

- UM 15.1.1 the responsibilities of the organization and the delegated entity;
- UM 15.1.2 the delegated activities;
- UM 15.1.3 the frequency of reporting to the organization;
- UM 15.1.4 the process by which the organization evaluates the delegated entity's performance and
- UM 15.1.5 the remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations.

UM 15.2 There is evidence that the organization:

- UM 15.2.1 evaluates the delegated entity's capacity to perform the delegated activities prior to delegation;
- UM 15.2.2 approves the delegated entity's UM program annually;
- UM 15.2.3 evaluates regular reports as specified in UM 15.1.3 and
- UM 15.2.4 evaluates annually whether the delegated entity's activities are being conducted in accordance with the organization's expectations and NCQA standards.

52.111: Appendix G: Standards for Quality Management and Improvement in the NCQA Standards and Surveyor Guidelines for the Accreditation of PPO Plans effective July 31, 2000

This Appendix includes material of which the NCQA is the copyright owner. Such material appears herein under license from the NCQA.

QI 1 Program Structure

The organization's quality improvement (QI) structures and processes are clearly defined and responsibility is assigned to appropriate individuals.

QI 1.1 A written description of the QI program outlines the program structure and content.

QI 1.1.1 The structure includes the responsibilities of each part of the organization that is involved in QI.

QI 1.1.2 The content includes:

QI 1.1.2.1 overall goals and objectives, including the PPO's approach to improving patient safety;

QI 1.1.2.2 the subjects addressed; and

QI 1.1.2.3 the quality indicators the organization currently uses.

QI 1.1.3 The description of the program specifically addresses the behavioral health care aspects of the program.

QI 1.1.4 The organization evaluates the program description annually and updates it as necessary.

QI 1.2 The organization involves appropriate personnel to carry out its QI program.

QI 1.2.1 The QI program is accountable to the governing body.

QI 1.2.2 A designated physician has substantial involvement in the implementation of the QI program.

QI 1.2.3 A designated behavioral health care practitioner is involved in the implementation of the behavioral health care aspects of the QI program.

QI 1.2.4 A committee oversees and is involved in QI activities.

QI 1.3 The QI program resources (e.g., personnel, analytic capabilities, data resources) are adequate to carry out the activities in the program description.

QI 2 Program Operations

The organization's quality improvement program is fully operational.

QI 2.1 The QI committee recommends policy decisions, reviews and evaluates the results of quality improvement activities, institutes needed actions and ensures follow-up, as appropriate.

QI 2.2 There are approved and signed minutes that reflect all QI committee decisions and actions.

QI 2.3 Upon request, the organization makes available to its enrollees and practitioners information about its QI program, including a description of the QI program and a report on the organization's progress in meeting its goals.

QI 3 Health Services Contracting

(Standard in effect as of July 1, 2001)

Contracts with individual practitioners and organizational providers, including those making UM decisions, specify that contractors cooperate with the organization's quality improvement program.

QI 3.1 Contracts with practitioners specifically require that:

QI 3.1.1 the organization has access to the practitioners' medical records to the extent permitted by state and federal law; and

QI 3.1.2 the organization allows open practitioner-patient communication regarding appropriate treatment alternatives and without penalizing practitioners for discussing medically necessary or appropriate care for the patient.

QI 3.2 Contracts with providers specifically require that the organization has access to the providers' medical records to the extent permitted by state and federal law.

QI 4 Availability of Practitioners

The organization ensures that its network is sufficient in numbers and types of practitioners.

QI 4.1 In creating and maintaining its delivery system of practitioners, the organization takes into consideration assessed linguistic and cultural needs and preferences of enrollees.

QI 4.2 The organization establishes standards for the number and geographic distribution of practitioners in key specialties.

QI 4.3 The organization collects and analyzes data to measure its performance against the standards established in QI 4.2.

QI 5 Accessibility of Services

The organization establishes mechanisms to assure the accessibility of medical services, behavioral health services and customer services.

QI 5.1 The organization establishes standards for access to medical care for the specialties of general and internal medicine, family practice, pediatrics, and obstetrics/gynecology:

QI 5.1.1 routine care;

QI 5.1.2 urgent care;

QI 5.1.3 emergency care and

QI 5.1.4 after-hours care.

QI 5.2 The organization establishes standards for key elements of telephone customer service.

QI 5.3 The hours of operation and service availability for behavioral health care reflect the needs of enrollees needing behavioral health care, as follows:

QI 5.3.1 An enrollee with life-threatening emergency needs is seen immediately.

QI 5.3.2 An enrollee with non-life-threatening emergency needs has access to care within 6 hours.

QI 5.3.3 An enrollee with urgent needs has access to care within 48 hours.

QI 5.3.4 An enrollee has access to a routine office visit within 10 working days.

QI 5.3.5 An enrollee has access to telephone services for centralized screening and triage, if applicable, as follows:

QI 5.3.5.1 callers reach a nonrecorded voice within 30 seconds and

QI 5.3.5.2 abandonment rates do not exceed 5 percent at any given time.

QI 5.4 The organization collects and analyzes data to measure its performance against the standards for high-volume practitioners.

QI 6 Enrollee Satisfaction

The organization implements mechanisms to assure enrollee satisfaction.

QI 6.1 The organization assesses enrollee satisfaction using appropriate data.

QI 6.1.1 The organization evaluates enrollee complaints and appeals.

QI 6.1.2 The organization conducts an additional systematic assessment of enrollees' issues.

QI 6.2 The organization uses appropriate methods to collect data for the activities listed in QI 6.1.

QI 6.2.1 The appropriate population is identified.

QI 6.2.2 If sampling is used, appropriate samples are drawn from the

affected population.

QI 6.2.3 Valid and reliable data are collected.

QI 6.3 The organization analyzes data for the activities listed in QI 6.1.

QI 6.4 The organization informs practitioners and providers of the results of enrollee satisfaction activities.

Standards QI 7 and QI 8

The standards are not included in PPO Plan Accreditation. The numbers are reserved to maintain consistency with NCQA's other accreditation programs.

QI 9 Continuity and Coordination of Care

The preferred provider organization promotes continuity and coordination of care that enrollees receive.

Note: QI 9.1 through 9.4 are not included in PPO Plan Accreditation. The numbers are reserved to maintain consistency with NCQA's other accreditation programs.

QI 9.5 The organization notifies enrollees affected by the termination of a practitioner or practice site at least 30 days prior to the effective termination date.

QI 9.6 When an in-network practitioner's contract is discontinued, given certain conditions, the organization allows enrollees to have continued access to that practitioner at in-network rates under the following circumstances:

QI 9.6.1 Enrollees undergoing active treatment for a chronic or acute medical condition have access to their discontinued practitioner through the current period of active treatment or for up to 90 days, whichever is shorter.

QI 9.6.2 Enrollees in their second or third trimester of pregnancy have access to their discontinued practitioner through the postpartum period.

Standards QI 10 and QI 11

The standards are not included in PPO Plan Accreditation. The numbers are reserved to maintain consistency with NCQA's other accreditation programs.

QI 12 Effectiveness of the QI Program

The organization initiates and evaluates activities to continuously improve the quality of service to its enrollees.

QI 12.1 The organization reviews analysis of quality indicators and activities against goals at least annually, and more often when appropriate.

QI 12.2 The organization identifies opportunities for improvement, establishes priorities for opportunities to address, and sets improvement goals.

QI 12.3 The organization designs and undertakes action to attain improvement goals in at least two areas annually.

QI 12.4 The organization evaluates its progress toward attaining improvement goals including its approach to improving patient safety at least annually, and the QI committee provides a written report to management.

[QI 12.5 *The organization determines whether there have been demonstrated improvements in the quality of service to enrollees.*] *

[QI 12.6 *There is evidence that QI activities have contributed to meaningful improvement in the quality of service provided to enrollees.*] *

QI 13 Delegation of QI Activity

If the organization delegates any QI activities, there is evidence of oversight of the delegated activity.

QI 13.1 A mutually agreed upon document describes:

- QI 13.1.1 the responsibilities of the organization and the delegated entity;
- QI 13.1.2 the delegated activities;
- QI 13.1.3 the frequency of reporting to the organization;
- QI 13.1.4 the process by which the organization evaluates the delegated entity's performance and
- QI 13.1.5 the remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations.

QI 13.2 There is evidence that the organization:

- QI 13.2.1 evaluates the delegated entity's capacity to perform the delegated activities prior to delegation;
- QI 13.2.2 approves the delegated entity's QI program description

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* *Sections of the standard that will be activated in 2003.*

annually;

QI 13.2.3 evaluates regular reports as specified in QI 13.1.3; and

QI 13.2.4 evaluates annually whether the delegated entity's activities are being conducted in accordance with the organization's expectations and NCQA standards.

52.112: Appendix H: Standards for Credentialing and Recredentialing in the NCQA Standards and Surveyor Guidelines for the Accreditation of PPO Plans effective July 31, 2000

This Appendix includes material of which the NCQA is the copyright owner. Such material appears herein under license from the NCQA.

CR 1 Credentialing Policies

The organization documents the mechanism for the credentialing and recredentialing of licensed practitioners with whom it contracts who treat enrollees outside the inpatient setting and who fall within its scope of authority and action. At a minimum, the policies and procedures define:

CR 1.1 the scope of practitioners covered;

CR 1.2 the criteria and the primary source verification of information used to meet these criteria;

CR 1.3 the process used to make decisions;

CR 1.4 the process to delegate credentialing or recredentialing;

CR 1.5 the right of practitioners to review the information submitted in support of their credentialing applications;

CR 1.6 the process for notification to a practitioner of any information obtained during the organization's credentialing process that varies substantially from the information provided to the organization by the practitioner;

CR 1.7 the practitioner's right to correct erroneous information;

CR 1.8 the medical director's or other designated physician's direct responsibility and participation in the credentialing program and

CR 1.9 the process used to ensure the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.

CR 2 Credentialing Committee

The organization designates a credentialing committee that makes recommendations regarding credentialing decisions using a peer-review process.

CR 3 Initial Primary Source Verification

At the time of credentialing, the organization verifies at least the following information from primary sources (unless otherwise indicated):

CR 3.1 a current valid license to practice;

CR 3.2 a valid DEA or CDS certificate, as applicable;

Note: DEA or CDS certificates are not applicable for chiropractors. CDS certificates are not applicable for dentists. However, DEA certificates may be applicable.

CR 3.3 education and training of practitioners;

CR 3.4 board certification if the practitioner states that he/she is board certified on the application;

Note: Verification of board certification is not applicable for chiropractors.

CR 3.5 work history;

Note: Primary source verification is not required for work history.

CR 3.6 history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner.

CR 4 Application and Attestation

The applicant completes an application for enrolleeship. The application includes a current and signed attestation by the applicant regarding:

CR 4.1 reasons for any inability to perform the essential functions of the position, with or without accommodation;[*]

CR 4.2 lack of present illegal drug use;[*]

CR 4.3 history of loss of license and felony convictions;

CR 4.4 history of loss or limitation of privileges or disciplinary activity;

CR 4.5 current malpractice insurance coverage and

CR 4.6 the correctness and completeness of the application.

CR 5 Initial Sanction Information

There is documentation that before making a credentialing decision, the organization has received the following information and includes this information in the credentialing files.

CR 5.1 The organization has received information from the National Practitioner Data Bank (NPDB) and includes it in the credentialing files.

Note: NPDB query is not required for chiropractors and podiatrists.

[*] The exact statement or inquiry may vary depending on applicable legal requirements such as the Americans with Disabilities Act (ADA).

CR 5.2 The organization has received information about sanctions or limitations on licensure as applicable and includes it in the credentialing files.

CR 5.3 The organization has reviewed for previous sanction activity by Medicare and Medicaid and includes it in this in the credentialing files.

Note: Medicare/Medicaid query is not applicable for dentists.

Standard CR 6

The standard is not included in PPO Plan Accreditation. The number is reserved to maintain consistency with NCQA's other accreditation programs.

CR 7 Recredentialing Primary Source Verification

The organization formally recredentials its practitioners at least every three years. During the recredentialing process it verifies at least the following information from primary sources (unless otherwise indicated):

CR 7.1 a valid state license to practice;

CR 7.2 a valid DEA or CDS certificate, as applicable;

Note: DEA or CDS certificates are not applicable for chiropractors. CDS certificates are not applicable for dentists.

CR 7.3 education and training of practitioners;

Note: If a practitioner's education and training was verified during the PPO's previous credentialing cycle using one of the sources listed in CR 3.3, no further action is necessary to meet the intent of CR 7.3.

CR 7.4 board certification, if the practitioner states that he/she is board certified;

Note: PPOs must verify board certification at recredentialing only if the practitioner's board certification has expired or is new since the practitioner's last credentialing. Board certification is not applicable for chiropractors.

CR 7.5 work history;

Note: Primary source verification is not required for work history. If a practitioner's work history was verified during the PPO's previous credentialing cycle using one of the sources listed in CR 3.5, no further action is necessary to meet the intent of CR 7.5.

CR 7.6 history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner; and

CR 7.7 a current, signed attestation by the applicant regarding:

CR 7.7.1 reasons for any inability to perform the essential functions of the position, with or without accommodation;*

CR 7.7.2 lack of present illegal drug use;*

CR 7.7.3 history of loss or limitation of privileges or disciplinary activity;

CR 7.7.4 current malpractice insurance coverage;

CR 7.7.5 the correctness and completeness of the application.

CR 8 Recredentialing Sanction Information

There is documentation that, before making a recredentialing decision, the organization has received the following information on the practitioner and includes this information in the recredentialing files.

CR 8.1 The organization has received information from the National Practitioner Data Bank and includes it in the recredentialing files.

Note: NPDB query is not required for chiropractors and podiatrists.

CR 8.2 The organization has received information about sanctions or limitations on licensure, as applicable, and includes it in the recredentialing files.

CR 8.3 The organization has reviewed for previous sanction activity by Medicare and Medicaid and records this in the recredentialing files.

Note: Medicare/Medicaid query is not applicable for dentists.

Standard CR 9

The standard is not included in PPO Plan Accreditation. The number is reserved to maintain consistency with NCQA's other accreditation programs.

CR 10 Ongoing Monitoring of Sanctions and Complaints

* The exact statement or inquiry may vary depending on applicable legal requirements such as the Americans with Disabilities Act.

The organization has implemented policies and procedures for the ongoing monitoring of practitioner sanctions and complaints between recredentialing cycles. The organization has taken appropriate action against practitioners when it identifies occurrences of poor quality.

CR 10.1 The organization has a written policy and procedure that addresses the ongoing monitoring and use of the following types of information:

CR 10.1.1 Medicare and Medicaid sanctions;

CR 10.1.2 sanctions or limitations on licensure and

CR 10.1.3 complaints.

CR 10.2 The organization implements the policy and procedure by regularly obtaining and reviewing documentation on sanctions and complaints.

CR 10.3 The organization implements appropriate interventions when it identifies occurrences of poor quality.

CR 11 Notification to Authorities and Practitioner Appeal Rights

When an organization has taken action against a practitioner for quality reasons, the organization offers a formal appeal process and reports the action to the appropriate authorities.

CR 11.1 The organization has procedures for, and documentation of implementation of, as appropriate, reporting of serious quality deficiencies that could result in a practitioner's suspension or termination to appropriate authorities.

CR 11.2 The organization has an appeal process for instances in which the organization chooses to alter the conditions of the practitioner's participation based on issues of quality of care and/or service. The organization informs practitioners of the appeal process.

CR 12 Assessment of Organizational Providers

The organization has written policies and procedures for the initial and ongoing assessment of organizational providers with which it intends to contract.

CR 12.1 The organization includes at least the following medical and behavioral health care providers:

CR 12.1.1 hospitals, home health agencies, skilled nursing facilities, nursing homes, and free standing surgical centers;

CR 12.1.2 behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting.

CR 12.2 The organization confirms that the provider is in good standing

with state and federal regulatory bodies and

CR 12.3 The organization confirms that the provider has been reviewed and approved by an accrediting body or

CR 12.4 If the provider has not been approved by an accrediting body, the organization develops and implements standards of participation.

CR 12.5 At least every three years, the organization confirms that the provider continues to be in good standing with the state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body.

CR 13 Delegation of Credentialing

If the organization delegates any credentialing and recredentialing activities, there is evidence of oversight of the delegated activity.

CR 13.1 A mutually agreed upon document describes:

CR 13.1.1 the responsibilities of the organization and the delegated entity;

CR 13.1.2 the delegated activities;

CR 13.1.3 the process by which the organization evaluates the delegated entity's performance and

CR 13.1.4 the remedies, including revocation of the delegation, available to the organization if the delegated entity does not fulfill its obligations.

CR 13.2 The organization retains the right, based on quality issues, to approve new practitioners, providers and sites and to terminate or suspend individual practitioners or providers.

CR 13.3 There is documentation that the organization:

CR 13.3.1 evaluates the delegated entity's capacity to perform the delegated activities prior to delegation and

CR 13.3.2 evaluates annually whether the delegated entity's activities are being conducted in accordance with the organization's expectations and NCQA standards.

52.113: Appendix I: Sections of Standards for Preventive Health Services in the NCQA Surveyor Guidelines for the Accreditation of MCOs effective July 1, 2001 that are relevant to nongatekeeper preferred provider plans

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PH 1 Adoption of Preventive Health Guidelines

The organization has preventive health guidelines for prevention or early detection of illness and disease.

PH 1.1 The organization has guidelines for the following categories as required under Massachusetts mandated benefit statutes:
Prenatal and perinatal care, including newborn hearing tests
Preventive care for infants and children up to 6 years

PH 1.2 Each guideline describes the prevention or early detection interventions and the recommended frequency and conditions under which the interventions are required.

52.114: Appendix J: Standards Points and Reporting Categories in Appendix 1 in the NCQA Standards and Surveyor Guidelines for the Accreditation of PPO Plans effective July 31, 2000

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A carrier shall not be accredited unless the carrier scores 65 percent or higher of the points described below for those requirements applicable to that carrier's health plans.

2001 Standard	Standard Description	2001 PPO Points
	Utilization Management	
UM 1	Utilization Management Structure	0.3
UM 2	Clinical Criteria for UM Decisions	3.1
UM 3	Appropriate Professionals	2.1
UM 4	Timeliness of UM Decisions	3.1
UM 5	Medical Information	1.8
UM 6	Denial Notices	2.3
UM 7	Appeal Policies and Procedures	1.5
UM 8	Handling of Appeals	5.4
UM 9	Evaluation of New Technology	2.3
UM 10	Satisfaction with the UM Process	3.8
UM 11	Emergency Services	2.3
UM 12	Procedures for Pharmaceutical Management	1.5
UM 13	[Not included in PPO standards]	--
UM 14	Triage and Referral for Behavioral Health Care	0.5
UM 15	Delegation of UM	Varies
	Total Utilization Management	**30**
	Quality Management and Improvement	
QI 1	Program Structure	1.0
QI 2	Program Operations	1.0
QI 3	Health Services Contracting	0.8
QI 4	Availability of Practitioners	3.0
QI 5	Accessibility of Services	5.0
QI 6	Enrollee Satisfaction	5.5
QI 7	[Not included in PPO standards]	--
QI 8	[Not included in PPO standards]	--
QI 9	Continuity and Coordination of Care	3.4
QI 10	[Not included in PPO standards]	--

2001 Standard	Standard Description	2001 PPO Points
QI 11	[Not included in PPO standards]	--
QI 12	Effectiveness of the QI Program	5.3
QI 13	Delegation of QI Activity	Varies
	Total Quality Management and Improvement	**25**
	Credentialing and Recredentialing	
CR 1	Credentialing Policies	0.3
CR 2	Credentialing Committee	0.5
CR 3	Initial Primary Source Verification	3.2
CR 4	Application and Attestation	1.1
CR 5	Initial Sanction Information	2.9
CR 6	[Not included in PPO standards]	--
CR 7	Recredentialing Primary Source Verification	2.9
CR 8	Recredentialing Sanctions	2.9
CR 9	[Not included in PPO standards]	--
CR 10	Ongoing Monitoring of Sanctions and Complaints	3.5
CR 11	Notification to Authorities and Practitioner Appeal Rights	1.1
CR 12	Assessment of Organizational Providers	1.6
CR 13	Delegation of Credentialing	Varies
	Total Credentialing and Recredentialing	**20**
	Preventive Health	
PH 1.1-1.2	Adoption of Preventive Health Guidelines	1.5
	Total Preventive Health	**1.5**